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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06183

CERTIFICATE OF DEATH

06180

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10 SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYVILLE, MD d. STREET ADDRESS CADD ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARUNHA Shepherdson ABELL		4. DATE OF DEATH 5 17 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-5-44
9. AGE (In years last birthday) 23 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Baltimore City		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE W. Abell of A		14. MOTHER'S MAIDEN NAME CONSTANCE Gill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219-42-0919	
17. INFORMANT FATHER - SAME ADDRESS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 473 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH WEEKS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-4 , 1967, to 5-17 , 1967, that (I) (we) lost the deceased alive on 5-16 - 1967, and that death occurred at 12:00 AM, from causes on and on the date stated above.			
22a. SIGNATURE R Vieta		22b. DATE SIGNED 5-17-67	
22c. PHYSICIAN'S NAME (Type) ROLANDO VIETA		22d. ADDRESS SPRING GROVE STATE HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF May-18-67	23c. NAME OF CEMETERY OR CREMATORY GreenMount	23d. LOCATION (City or town) (County) (State) Baltimore Md. 21202
24. FUNERAL DIRECTOR Stewart & Mowen Co 108-North-Av (21201)		25. REC'D BY REGISTRAR MAY 18 1967	
25b. REGISTRAR'S SIGNATURE J Charles Judge			

08130

08120

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

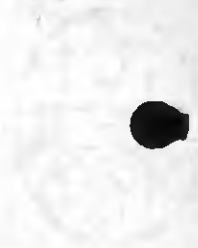
06190

06181

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>11fe</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto medical Center</u>				d. STREET ADDRESS <u>3409 White Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alice</u> First <u>(Estelle)</u> Middle <u>10ELL</u> Last <u>Adams</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>18</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/29/10</u>	9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Henry Price</u>				14. MOTHER'S MAIDEN NAME <u>Fanny Saunders</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Admission Sheet</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the lung with Metastasis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <u>2 Months</u> <u>2 Months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-9</u> , 19 <u>67</u> , to <u>5-18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/17</u> 19 <u>67</u> , and that death occurred at <u>335AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Derek A. Bruce</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>5/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DEREK A. BRUCE</u>				22d. ADDRESS <u>C.B.M.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/22/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert C. Altenburg - 6009 Harford Rd.</u> <u>Funeral Home, Inc.</u>				25a. REC'D BY REGISTRAR <u>MAY 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jago</u>	

1213

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Volume 12, Number 1 - 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06191 CERTIFICATE OF DEATH 06182

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 10mth6dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex, Maryland 21221 d. STREET ADDRESS 1644 Eastern Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle M. Last Adams		4. DATE OF DEATH Month May Day 9 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1884
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR: Months 03 Days 1 IF UNDER 24 HRS. Hours 03 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) molding		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Joseph Adams		14. MOTHER'S MAIDEN NAME Catherine Scriver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UPK		16. SOCIAL SECURITY NO. 213-01-4135	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Generalized arteriosclerosis, severe (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from June 1, 1966 to May 9, 1967 , that (we) last saw the deceased alive on May 9, 1967 , and that death occurred at 11:55 M, from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 5-9-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/12/67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Vernon		23d. LOCATION (City, town or county) (State) Baltimore	
24. FUNERAL DIRECTOR J. H. Connelly Sons		25a. REC'D BY REGISTRAR 300 more	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		DATE MAY 12 1967	

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06192		06183	
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE M.D. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b Hours	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		d. STREET ADDRESS 238 BURKE AVE.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. JOSEPH HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last VIRGINIA Denmead AIKEN		4. DATE OF DEATH Month Day Year MAY 31 19 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-85
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Partner		10b. KIND OF BUSINESS OR INDUSTRY Master Tile Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua T. Kelley		14. MOTHER'S MAIDEN NAME May Parks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-30-5144	
17. INFORMANT Mrs. Virginia D. Ruley		Address 238 Burke Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William A. Pilisbury M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William A. Pilisbury		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> md. Address (Street, city, town, or county) Baltimore, Md.		22. DATE SIGNED 5-31-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/3/67	
23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204		25a. REC'D BY REGISTRAR 11 JUN 5 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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06193

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05184

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkton - Rural</u>				c. LENGTH OF STAY IN 1b <u>6.8 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MT Carmel Road</u>				e. STREET ADDRESS <u>7th Carmel Road</u>			
3. NAME OF DECEASED (Type or print) <u>Florence Virginia ALBAN</u>				4. DATE OF DEATH <u>May 18 1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-23-1890</u>	
9. AGE (In years, last birthday) <u>76 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Ireland, Mayland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
13. FATHER'S NAME <u>John McCann</u>				14. MOTHER'S MAIDEN NAME <u>Virginia AYRES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>218-22-4992</u>		17. INFORMANT <u>Mrs Mary Ruth Wilkins</u> Address <u>Parkton Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> 4221 DUE TO <u>Chronic myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-17</u> , 19 <u>67</u> , to <u>5-18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-18</u> , 19 <u>67</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E. Bush</u>				22b. DATE SIGNED <u>5/18/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				22d. ADDRESS <u>HAMPSTEAD Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/21/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PINEGROVE</u>		23d. LOCATION (City, town or county) (State) <u>ROCKTON, MD.</u>	
24. FUNERAL DIRECTOR <u>John E. Goff</u>				25a. REC'D BY REGISTRAR <u>HAMPSTEAD, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>John E. Goff</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

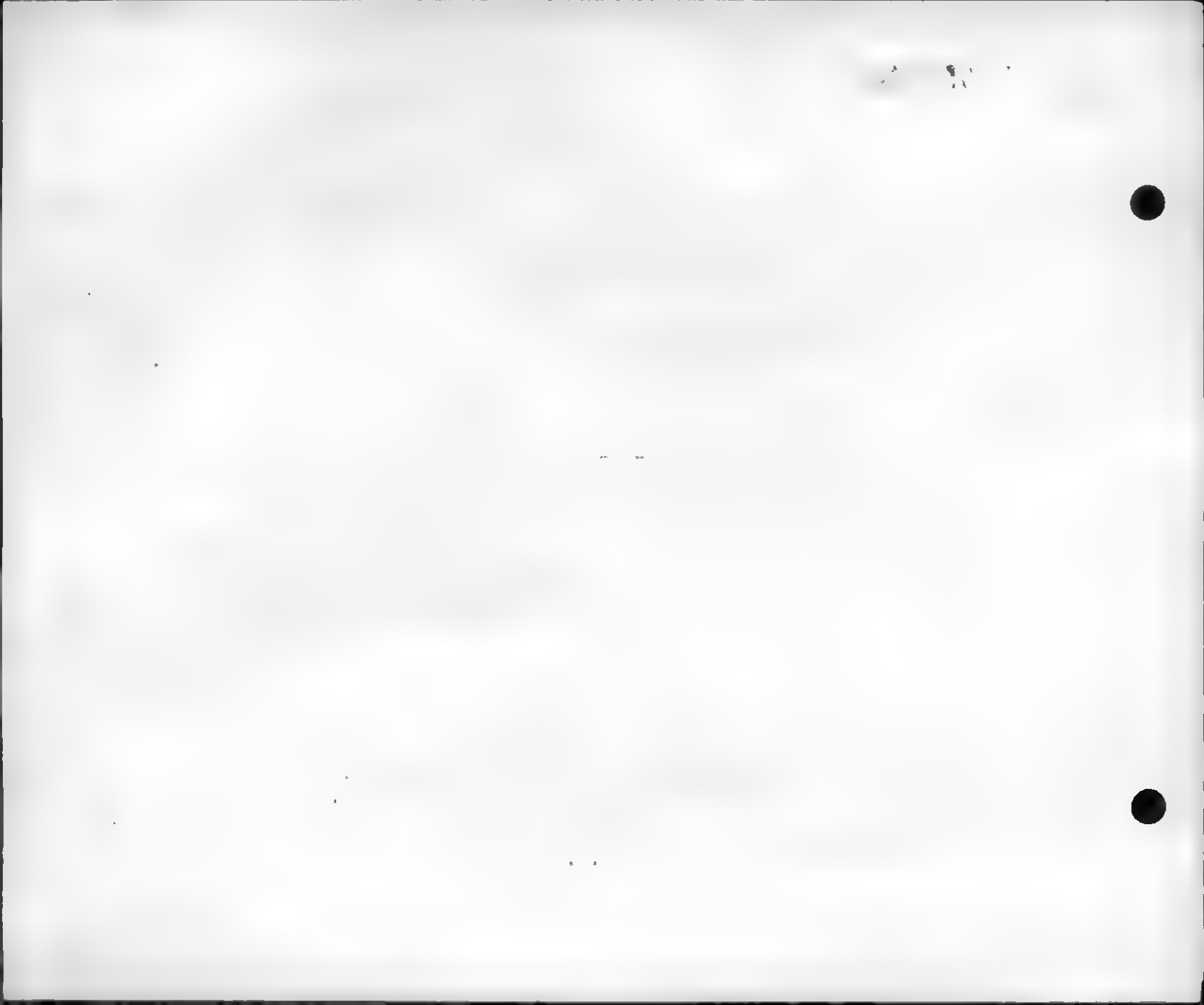
06194

CERTIFICATE OF DEATH

07661

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 23yr2mth6dys		c. CITY OR TOWN (If outside corporate limits, write RURA. and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 2101 Cold Spring Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle (Kratz) Last Alexander				4. DATE OF DEATH Month May Day 22 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1896		9. AGE (In years last birthday) 70 yrs	10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) guard		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Kratz				14. MOTHER'S MAIDEN NAME Margaret Helwig			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217-03-6680		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pyelonephritis with uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis, severe						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from March 13, 19 64 to May 22, 19 67 , that (1) the last saw the deceased alive on May 22, 19 67 , and that death occurred at 2:45 M, from causes and on the date stated above							
22a. SIGNATURE Stella Wachslar M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 5-22-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR JUN 7 1967	
						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

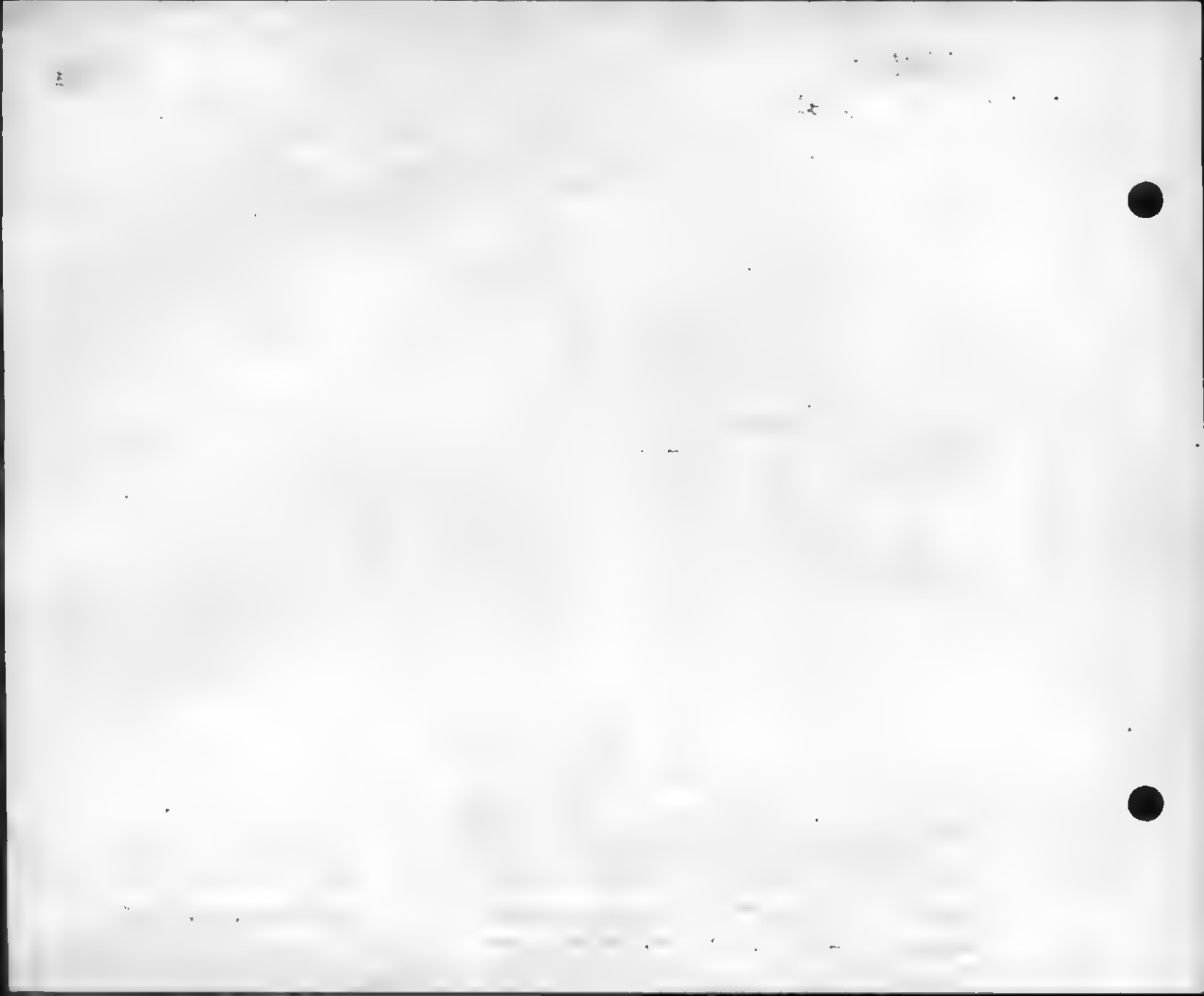
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06195 CERTIFICATE OF DEATH 06195

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balti</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL LOCHearn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL LOCHearn</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6417 LIBERTY Road</u>				d. STREET ADDRESS <u>6417 LIBERTY Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>C.</u> Last <u>ALLEN</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 25, 1905</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u> Hours <u>10</u> Min.		IF UNDER 24 HRS. Months <u>6</u> Days <u>10</u> Hours <u>10</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll County MD.</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>			
13. FATHER'S NAME <u>William ARBAUGH</u>				14. MOTHER'S MAIDEN NAME <u>ANN WILHIDE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-48-2402</u>		17. INFORMANT <u>Husband</u> Address <u>MR. GEORGE ALLEN 6417 LIBERTY Rd BALTIMORE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF BREAST to metastasize</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 13, 1954</u> to <u>MAY 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAY 10, 1967</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edwin L Pierpont</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWIN L PIERPONT, M.D.</u>				22d. ADDRESS <u>8204 LIBERTY Rd - BALTIMORE, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md. 21207</u>	
24. FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown</u>				25a. REC'D BY REGISTRAR <u>MAY 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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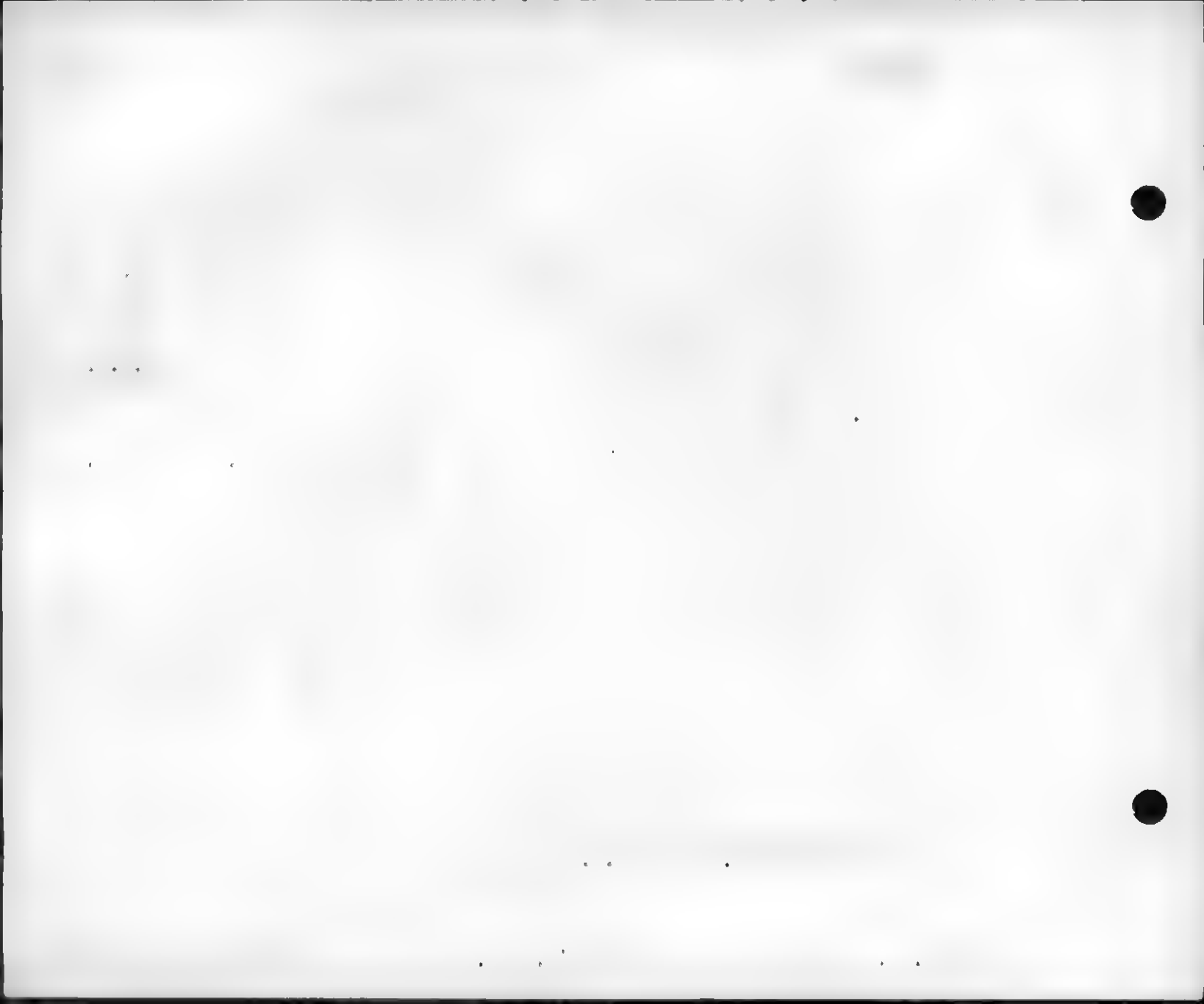
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06196

CERTIFICATE OF DEATH

06186

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN b 135 DAYS		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 1420 SOUTH CHARLES STREET	
3 NAME OF DECEASED (Type or print) First JACK Middle PHILLIP Last AMBROSE		4 DATE OF DEATH Month MAY Day 20 Year 1967	
5 SEX MALE	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/6/19
9 AGE (In years last birthday) 47 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN	
10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11 BIRTHPLACE (County & State, or foreign country) FREDERICK, MARYLAND	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DAVID L. AMBROSE	
14. MOTHER'S MAIDEN NAME MARY PHILLIPS		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII	
16 SOCIAL SECURITY NO 214 14 17 78		17 INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA WITH METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that this hospital attended the deceased from JAN 5 , 1967 to MAY 20 , 1967, that we last saw the deceased alive on MAY 20 , 1967, and that death occurred at 8:10 P.M. , from causes and on the date stated above.			
22a. SIGNATURE <i>Peter V. Juvan</i>		22b. DATE SIGNED 5/20/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M.D.		22d. ADDRESS VAH, FORT HOWARD, MARYLAND	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 5/24/67	23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND	23d LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR CHAS. L. STEVENS FUNERAL HOME BALTO., MD.		25a REC'D BY REGISTRAR MAY 23 1967	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

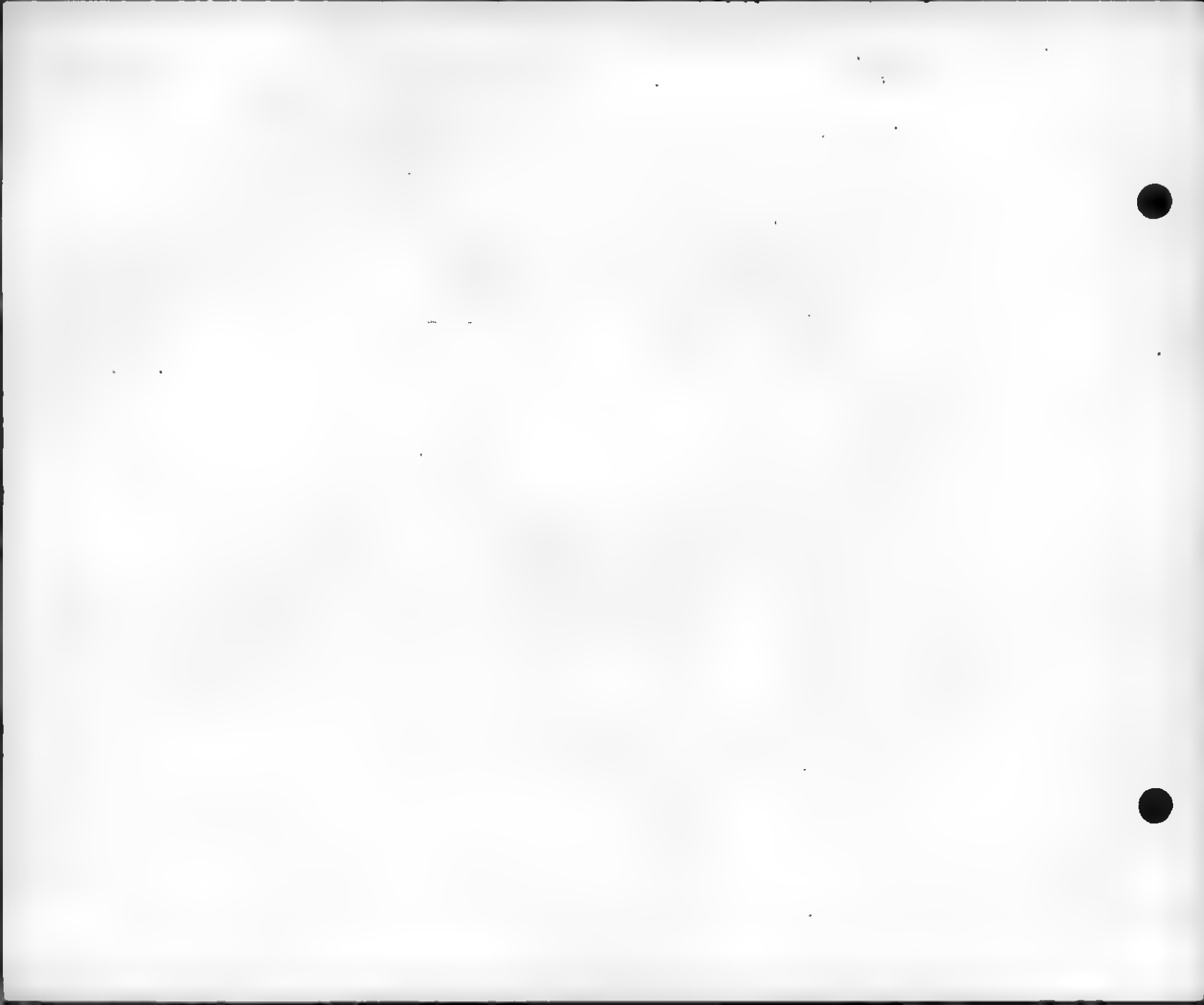
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06197

CERTIFICATE OF DEATH

06197

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. fa., give street address) Spring Grove State Hospital		d. STREET ADDRESS 1711 Wilkens Avenue	
3 NAME OF DECEASED (Type or print) First Bertha Middle A. Last Appler		4 DATE OF DEATH MAY 6 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-19-93
9 AGE (In years last birthday) 73 Y'S		IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adolph		14 MOTHER'S MAIDEN NAME Marie	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) —		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) none	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from April 20, 1967 , to 5/6 , 1967, that (X) (we) last saw the deceased alive on 5/6 , 1967, and that death occurred at 3:25 AM , from causes and on the date stated above.			
22a. SIGNATURE NARCISO M. PRINONA M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) NARCISO M. PRINONA		22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/9/67	
23c. NAME OF CEMETERY OR CREMATORY London Park		23d. LOCATION (City or Town) (County) (State) BALTO MD	
24. FUNERAL DIRECTOR Witzke F.H. Baeto Md.		25a. REC'D BY REGISTRAR MAY 8 1967	
25b. REGISTRAR'S SIGNATURE James J. Jones		DATE	

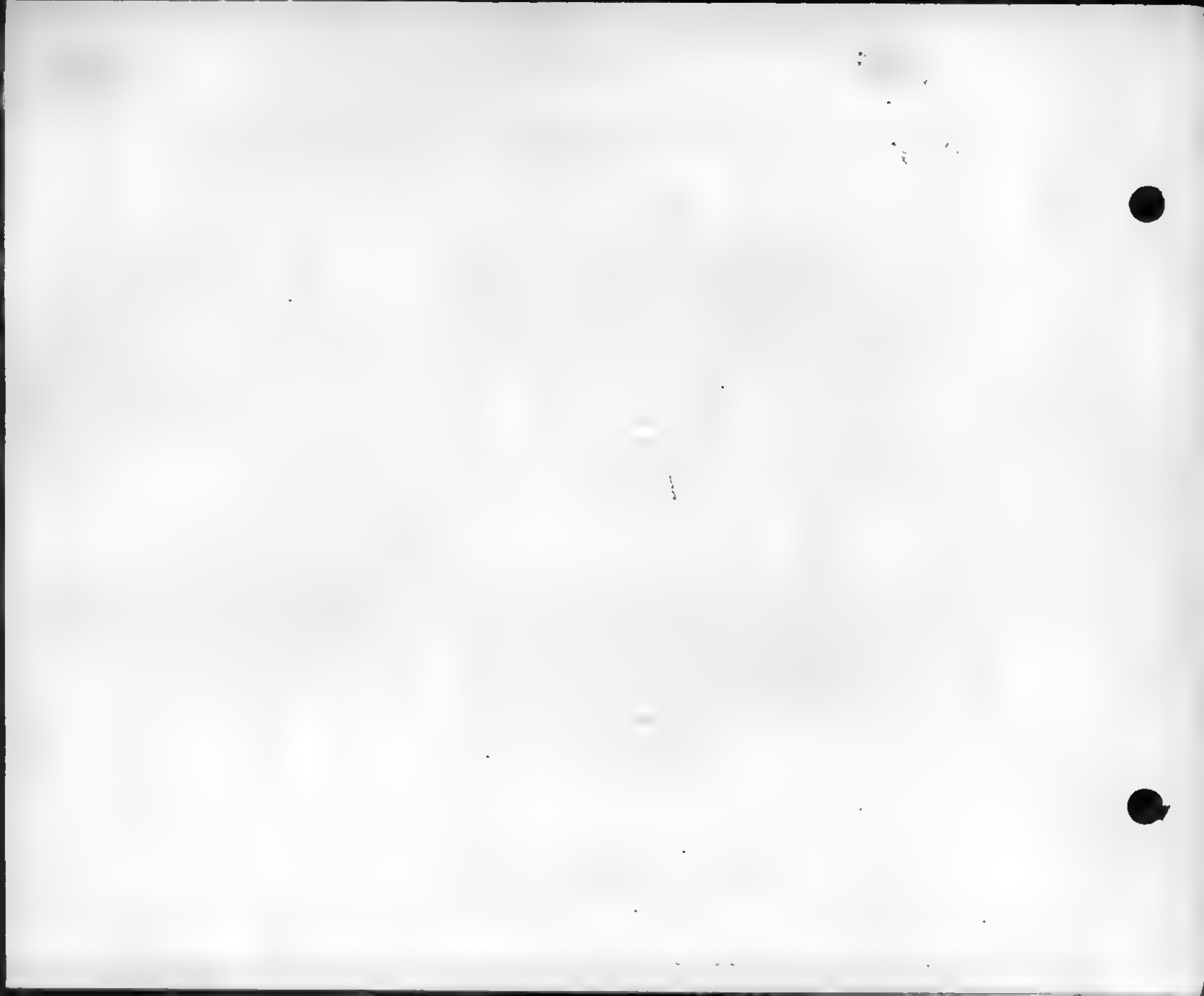


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06198
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodlawn</u> c. LENGTH OF STAY IN 1b <u>7 Years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2121 GWYNN OAK AVE</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WOODLAWN</u> d. STREET ADDRESS <u>3800 WINDSOR MILL RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>ERNEST</u> Last <u>ARMACOST</u>		4. DATE OF DEATH Month <u>5</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15/1910</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BARBER</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>
13. FATHER'S NAME <u>JOHN E. ARMACOST</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-05-4839</u>	
17. INFORMANT <u>MARGARET ARMACOST - 2121 GWYNN OAK AVE.</u>		Address <u>BALTO. 21207 MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA & METASTASES (OF RECTUM)</u> 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>DUE TO</u> (c) <u>DUE TO</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 15, 1933</u> to <u>MAY 2, 1967</u> , that (I) (we) last saw the deceased alive on <u>APRIL 30, 1967</u> , and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edwin E. Pierpont</u>		22b. DATE SIGNED <u>5/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWIN E. PIERPONT, M.D.</u>		22d. ADDRESS <u>8204 LIBERTY RD. BALTO. 21207 MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5-5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Md</u>
24. FUNERAL DIRECTOR <u>Ellsworth Armacost</u>		25a. REC'D BY REGISTRAR <u>4600 Liberty Heights Ave</u> 25b. REGISTRAR'S SIGNATURE DATE <u>MAY 1967</u>	



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1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

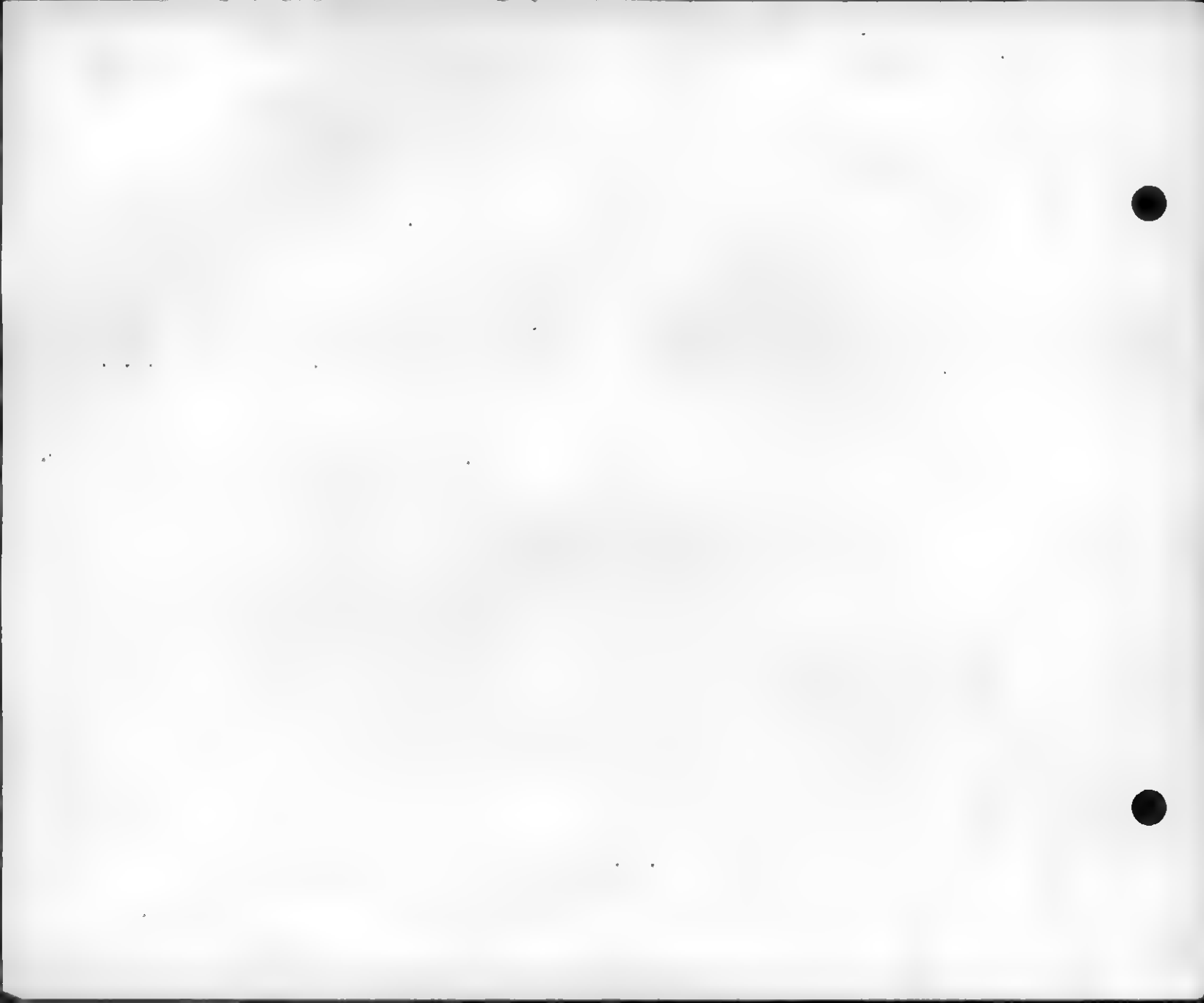
06199

Item 23b, File # 3309 5/24/67 kk

CERTIFICATE OF DEATH

06189

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 21201			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 770 W. SARATOGA STREET, APT 208		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First MARVIS Middle A. Last ARMSTRONG				4. DATE OF DEATH Month MAY Day 16 Year 19 67			
5 SEX FEMALE	6 COLOR OR RACE NEGRO	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Separated <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH APRIL 13, 1932		9 AGE (In years last birthday) 35 yrs	10 UNDER 1 YEAR Months Oays Hours Min	11 UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) NURSING ASSISTANT		10b. KIND OF BUSINESS OR IND. STRY HOSPITAL		11 BIRTHPLACE (County & State, or foreign country) GREENVILLE, N. C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME JESSIE ALLEN				14 MOTHER'S MAIDEN NAME ROSETTA DICKSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 219 34 67 77		17 INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMOLYTIC CRISIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) SICKLE CELL ANEMIA DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 5/14/67 , 19 67 , to 5/16/67 , 19 67 , that (s) (we) last saw the deceased alive on 5/16/67 , 19 67 , and that death occurred at 12:10 PM on causes and on the date stated above.							
22a. SIGNATURE <i>George Dudas</i> , M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/16/67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/20/67		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.	
24 FUNERAL DIRECTOR 1727 N. Monroe St.		ADDRESS PHILLIPS FUNERAL HOME		25a. REC'D BY REGISTRAR DATE MAY 22 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>14 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>G.B.M.C.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> d. STREET ADDRESS <u>5509 Gwynn Oak Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>NNN</u> Last <u>Arnold</u>				4. DATE OF DEATH Month <u>5</u> Day <u>11</u> Year <u>1967</u>				5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>2-17-75</u> 9. AGE (In years last birthday) <u>92</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co. Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Wm. Samuel Arnold</u> 14. MOTHER'S MAIDEN NAME <u>Younger, Anna</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u> 16. SOCIAL SECURITY NO. <u>218-18-0833-J1</u> 17. INFORMANT <u>Raymond A. Arnold</u> Address <u>600 Coventry Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4-26</u> , 19 <u>67</u> , to <u>5-11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-10</u> , 19 <u>67</u> , and that death occurred at <u>1200</u> A.M., from the causes and on the date stated above.											
22a. SIGNATURE <u>Manuel A. Gongon</u> 22b. DATE SIGNED <u>5-11-67</u>				22c. PHYSICIAN'S NAME (Type) <u>MANUEL A. GONGON</u> 22d. ADDRESS <u>GBMC-TOWSON, MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>May 13, 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Hereford Bap. Ch. Cemt Hereford, Md.</u> 23d. LOCATION (City, town or county) (State)				24. FUNERAL DIRECTOR <u>STERLING FUNERAL ESTATE</u> 25a. REC'D BY REGISTRAR <u>MAY 15 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06201					06191				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE				
Baltimore					Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe				
c. LENGTH OF STAY IN 1b 2 Yrs.					d. STREET ADDRESS 4714 Washington Blvd.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4714 Washington Blvd.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Renee Arthur					4. DATE OF DEATH May 1, 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/9/82		9. AGE (in years last birthday) 84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME George R. Hayden					14. MOTHER'S MAIDEN NAME Elizabeth Hixson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 219-54-4146				
					17. INFORMANT Mary H. Greff 4714 Washington Blvd				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular disease 45+1 DUE TO (b) Chaperonitis of age 10 yrs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Totaly blind for 5 yrs									
INTERVAL BETWEEN ONSET AND DEATH 54 hrs									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Jan 1967, to May 1, 1967, that (I) (we) last saw the deceased alive on Apr 29 1967, and that death occurred at 2 PM, from the causes and on the date stated above.									
22a. SIGNATURE Dr. Bruce B. Brumbaugh					22b. DATE SIGNED May 1/67				
22c. PHYSICIAN'S NAME (Type) Dr. Bruce B. Brumbaugh					22d. ADDRESS 5609 Main St. Elkridge				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 5/2/67				
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery					23d. LOCATION (City, town or county) (State) Parsy Maryland				
24. FUNERAL DIRECTOR Ambrose Inc. 1329 S. Lophur Sp. Rd					25a. REC'D BY REGISTRAR MAY 4 1967				
					25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

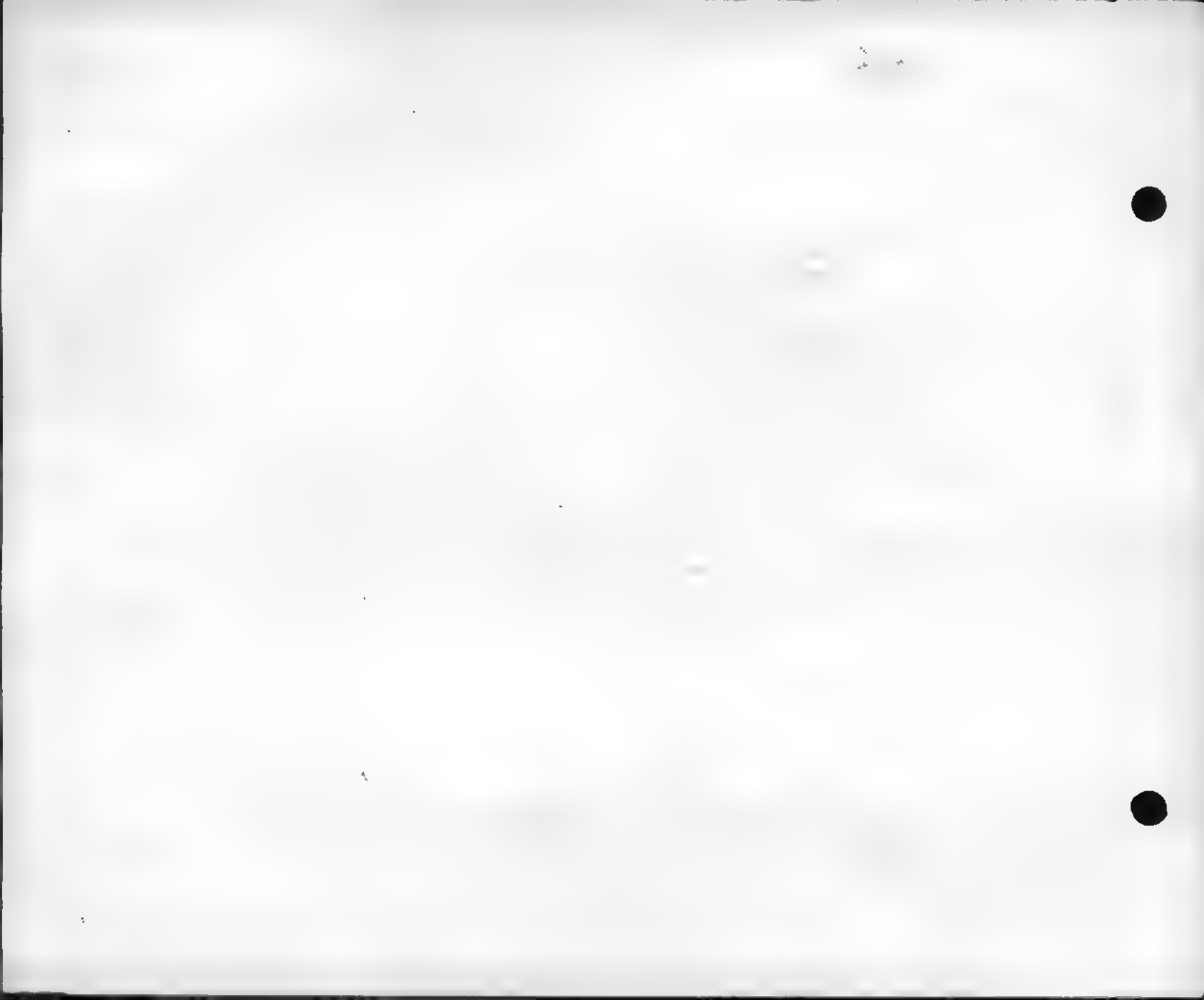
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06202

CERTIFICATE OF DEATH

06192

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c LENGTH OF STAY IN 1b 6 YEARS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ARMACOST NURSING HOME		d STREET ADDRESS 1014 N. CHARLES ST	
3 NAME OF DECEASED (Type or print) MAE N. BACHMANN		4 DATE OF DEATH Month MAY Day 16 Year 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MAY 22 1877
9 AGE (In years last birthday) 89 yrs		10 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DETECTIVE	
11 BIRTHPLACE (County & State or foreign country) CARLISLE, PENNSYLVANIA		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME PHILIP NORMAN		14 MOTHER'S MAIDEN NAME MATTIE (NOT KNOWN)	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16 SOCIAL SECURITY NO C. RAY FREHN, CARLISLE, PA.	
17 INFORMANT C. RAY FREHN, CARLISLE, PA.		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma of Colon Condit ons, if any, which gave rise to immediate cause (a), stating the underlying cause last Generalized Arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 Months	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/4/67 to MAY 16 1967 , that (I) (we) lost saw the deceased alive on 5/2/67 , and that death occurred at 7 PM , from causes and on the date stated above.			
22a SIGNATURE Charles E. O'Donnell		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) Charles E. O'Donnell, M.D.		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF MAY 18 1967	23c NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEMETERY	23d LOCATION (City or town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR Wm COOK-BROOKS TOWSON		25a REC'D BY REG. STRAR TOWSON, MD. 21204	25b REGISTRAR'S SIGNATURE Wm Cook-Brooks



FOR STATE
HEALTH DEPT.

06203

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #13 & 14 Film #G3-8-5-9-67 p2

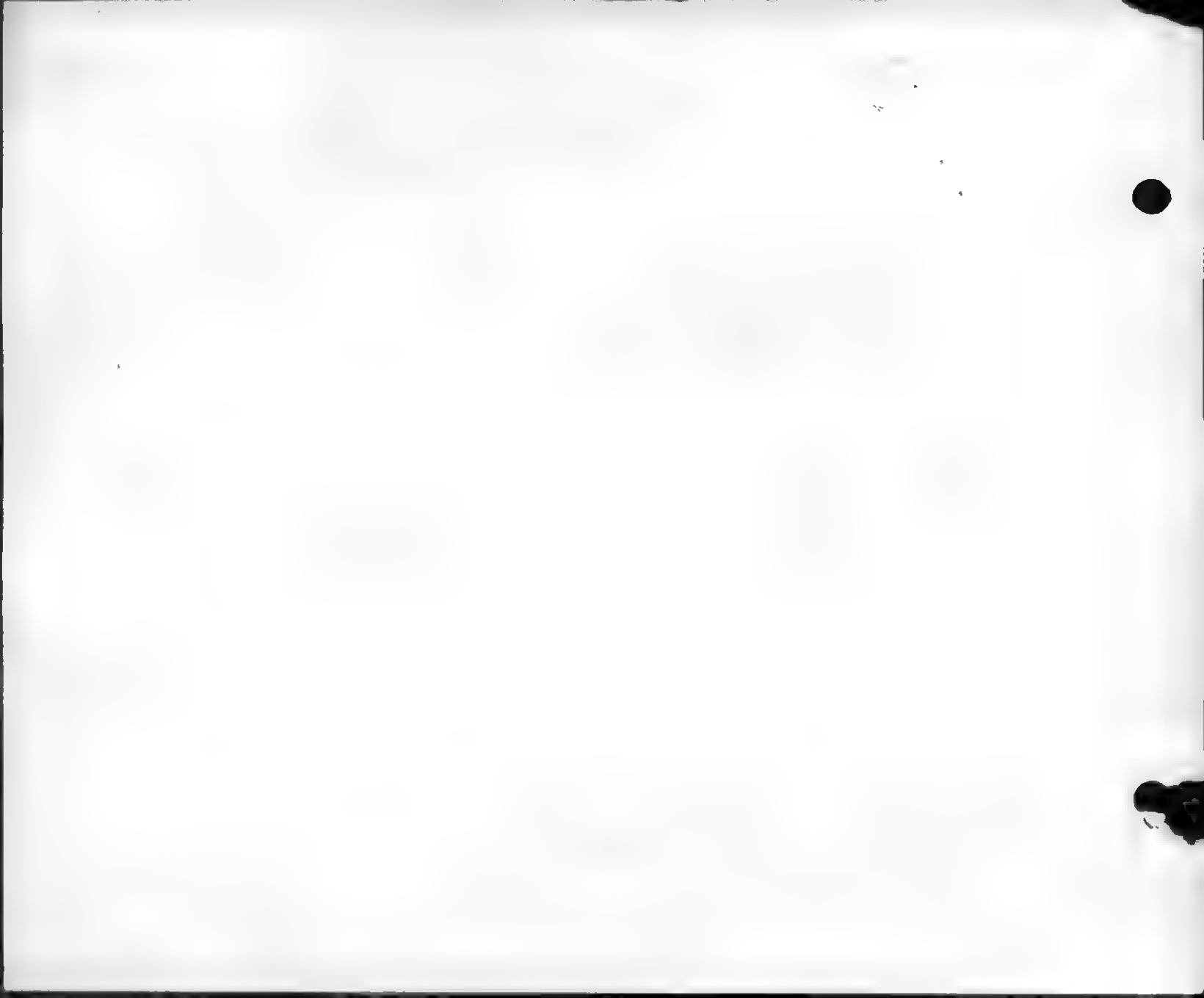
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06193

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived) (If institution: Residence before admission) a STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Dundalk		c LENGTH OF STAY N 1b Dundalk	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7302 School Lane		d STREET ADDRESS 7302 School Lane	
3 NAME OF DECEASED (Type or print) Orval Roy Baker		4 DATE OF DEATH May 3 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 16, 1899
9 AGE (in years last birthday) 68		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		10b KIND OF BUSINESS OR INDUSTRY Steel	
11 BIRTHPLACE (State or foreign country) West Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Samuel Baker		14 MOTHER'S MAIDEN NAME Kimvall Baker	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 236-01-8725	
17 INFORMANT Mrs. Edna N. Baker		Address 7302 School Lane	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Colonial occlusion 4201 DUE TO (b) Hypertensive C-V Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH —
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) No	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis, M.D.		22. DATE SIGNED	
EXAMINER'S NAME (Type) M.B. Davis, M.D.		Address (Street, city, town or county) 6800 Mornington Rd.	
23a BURIAL OR CREMATION REMOVAL (Specify) Burial	23b DATE OF BURIAL 5/6/67	23c NAME OF CEMETERY OR CREMATOR Baltimore Cemetery	23d LOCATION (City or town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR Ulrich Funeral Home Dundalk, Md.		25a REC'D BY REGISTRAR MAY 5 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	

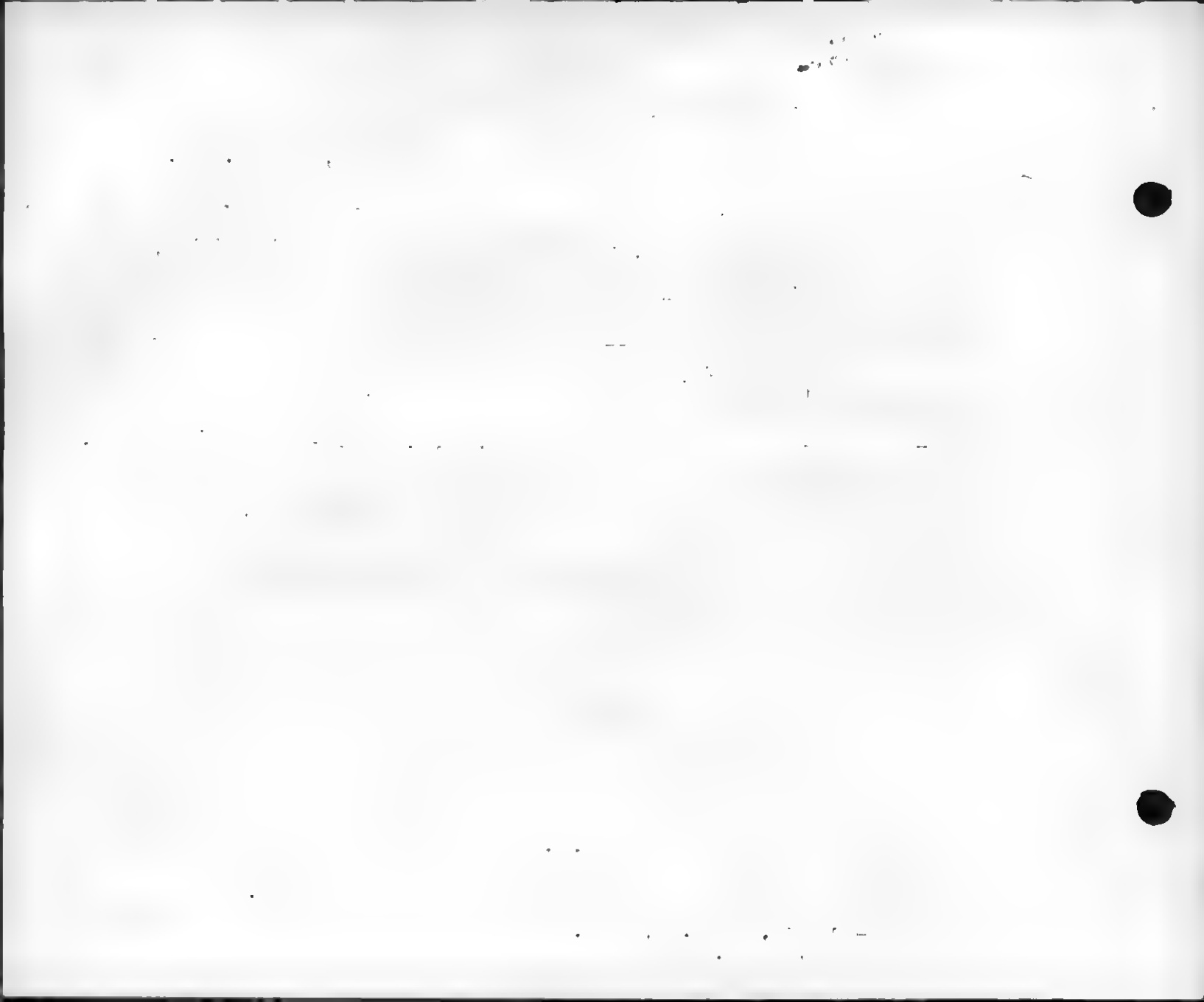
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>9807 Hilltop Drive</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville, Balto. Co.</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville, Balto. Co.</u>				d. STREET ADDRESS <u>9807 Hilltop Drive</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9807 Hilltop Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET E. BARLOW</u>				4. DATE OF DEATH Month Day Year <u>May 17th, 1967</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 1880</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Ireland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Thomas O'Neill</u>				14. MOTHER'S MAIDEN NAME <u>Julia Keelty</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>--</u>				17. INFORMANT Address <u>Mrs. J.E. Albert-9807 Hilltop Dr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis with Cerebral thrombosis</u> → 8 hrs. DUE TO (b) <u>Chronic Cardiac Decompensation</u> → 10 yrs. DUE TO (c) <u>Chronic Cardiac Decompensation</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)				20h. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>66</u> , to <u>April</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>14 April</u> 19 <u>67</u> , and that death occurred at <u>1 1/2</u> M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Thomas I. Brennan</u>				22b. DATE SIGNED <u>19 May 1967</u>				22c. PHYSICIAN'S NAME (Type) <u>Thomas Brennan M.D.</u>			
22d. ADDRESS <u>5217 Harford Road</u>				22e. ADDRESS <u>5217 Harford Road</u>				22f. ADDRESS <u>5217 Harford Road</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/20/67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem</u>			
23d. LOCATION (City, town or county) (State) <u>Balto.</u>				23e. LOCATION (City, town or county) (State) <u>Balto.</u>				23f. LOCATION (City, town or county) (State) <u>Balto.</u>			
24. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home, Inc.</u>				24a. ADDRESS <u>6500 York Rd. 21212</u>				25a. REC'D BY REGISTRAR <u>MAY 23 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25d. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

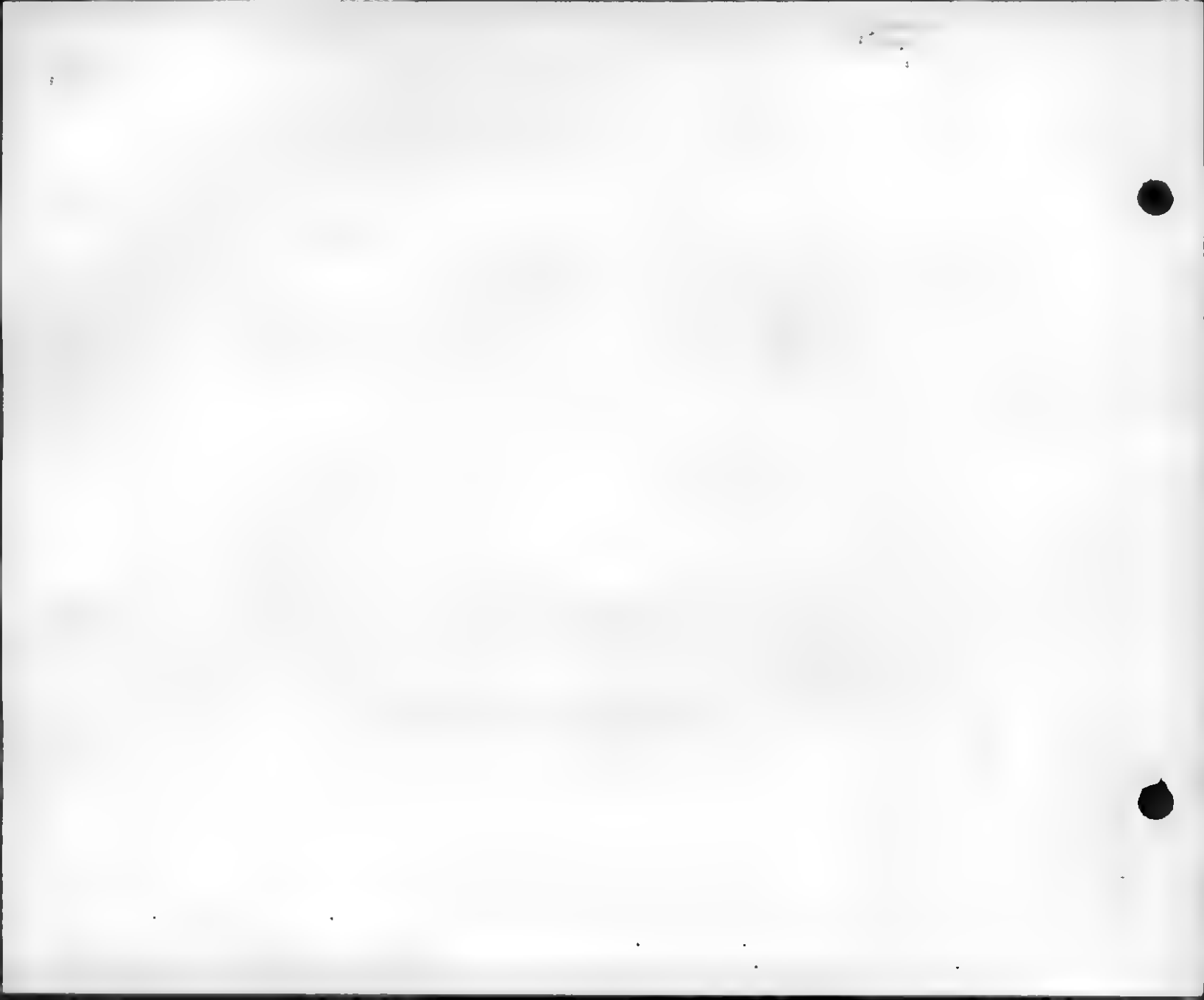


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MAY 16 1966										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Baltimore County										
CERTIFICATE OF DEATH										
00195										
1. PLACE OF DEATH a. COUNTY <u>Towson</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
					<u>Baltimore</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wm. Cook-Brooks Inc. + Home</u>					d. STREET ADDRESS <u>Maryland</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Lillian Beattie</u>					4. DATE OF DEATH Month Day Year <u>May 11 1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-10-1977</u>		9. AGE (In years last birthday) <u>29 yrs</u>		
						10. UNDER 1 YEAR Months Days Hours Min <u>9 16 15 15</u>		11. UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Mr. J. J. Beattie</u>					14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>James M. Beattie 613</u>				
						Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Heart Disease</u> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchitis, Spinal Curvature</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , to <u>May 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 9, 1967</u> , and that death occurred at <u>4:20 AM</u> , from causes and on the date stated above.										
22a. SIGNATURE <u>Norman Edward Day</u> M.D.					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22b. DATE SIGNED <u>May 11, 1967</u>		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS <u>H-2-33rd St Baltimore Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>			23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Inc. Baltimore, Md. 21202</u>					25a. REC'D BY REGISTRAR <u>MAY 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06206

06196

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12 c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Armocost N. H.			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg d. STREET ADDRESS 105 Chestnut St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Charles William Beall			4. DATE OF DEATH Month May Day 1 Year 1967		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1887	9. AGE (in years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 79 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railway Mail Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Charles E. Beall			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 577-58-8836		
17. INFORMANT Mrs. Mary E. O'Brien			Address 4439 Old York Rd. Balto., Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sympathetic Sarcoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 10, 1967 to May 1, 1967 , that (I) (we) last saw the deceased alive on May 1, 1967 , and that death occurred at 1201 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Laurence C. Post			22b. DATE SIGNED 5/1/67		
22c. PHYSICIAN'S NAME (Type) Dr. Laurence C. Post			22d. ADDRESS 6805 York Rd., Balto., 12, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-3-67		23c. NAME OF CEMETERY OR CREMATORY St. Rose	
23d. LOCATION (City, town or county) (State) Gaithersburg Md.		24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR MAY 2 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. ADDRESS 4905 York Rd. Balto., Md.			



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MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06207

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN it 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) 608 Stacy Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle Mary Last Beeler		4. DATE OF DEATH Month May Day 2 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1893
9. AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months 1 Days 18 Hours 15 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) not employed		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Melvin Holland		14. MOTHER'S MAIDEN NAME Delia Grady	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 217-03-4821	
17. INFORMANT Mr. Charles Beeler 608 Stacy Court		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) art scl cv disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 18 min 6 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a.m. none p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/4, 1965 to 5/2, 1967 , that (I) (we) last saw the deceased alive on 5/2, 1968 , and that death occurred at 1 PM , from causes and on the date stated above			
22a. SIGNATURE Maurice Feldman M.D.		22b. DATE SIGNED 5/3/67	
22c. PHYSICIAN'S NAME (Type) 2 E READ ST		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 5, 1967	
23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery		23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson		25a. REC'D BY REGISTRAR DATE MAY 5 1967	
ADDRESS 1050 York Road Towson, Maryland 21204		25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH

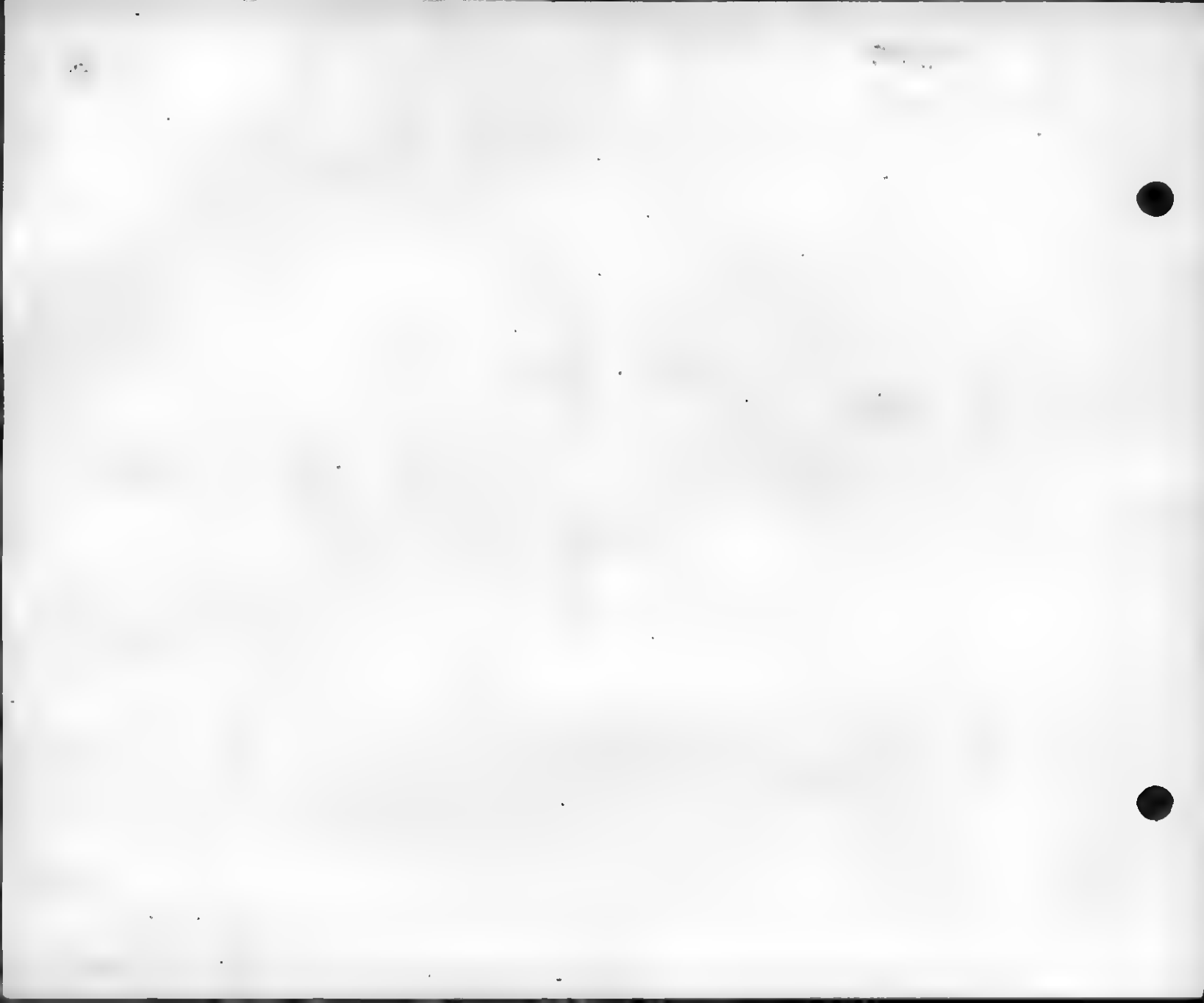
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06208

06198

1 PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
c. LENGTH OF STAY IN 1b 6 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTO. COUNTY GEN. HOSP		e. STREET ADDRESS 4105 COLONIAL RD	
3 NAME OF DECEASED (Type or print) ORVILLE W. BENEDICT		4 DATE OF DEATH Month May Day 11 Year 19 67	
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12/13/81
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Chief Inspector Balto. Commerce		10b KIND OF BUSINESS OR INDUSTRY Chamber of Commerce	11 BIRTHPLACE (County & State, or foreign country) Illinois
13 FATHER'S NAME Jared D. BENEDICT		14. MOTHER'S MAIDEN NAME Rose Van Gundy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO.	
17 INFORMANT Mrs. Carmelite B. Benedict same address		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT 143X DUE TO PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) H CVD; CHF DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 11 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETIS MELLITUS			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/5/67 , 19 67 to 5/11/67 , 19 67 , that (I) (we) last saw the deceased alive on 5/11/67 , 19 67 , and that death occurred at 8:15 PM , from causes and on the date stated above.			
22a SIGNATURE Dr. Gerald Maggidi		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 5/11/67
22c. PHYSICIAN'S NAME (Type) GERALD MAGGIDI		22d. ADDRESS BALTO. COUNTY HOSP	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/15/1967	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial Cem.	23d LOCATION (City or Town) (County) (State) Towson, Md.
24. FUNERAL DIRECTOR Wm. F. Tschernak		25a. REC'D BY REGISTRAR DATE MAY 16 1967	25b. REGISTRAR'S SIGNATURE Charles J. Maggidi

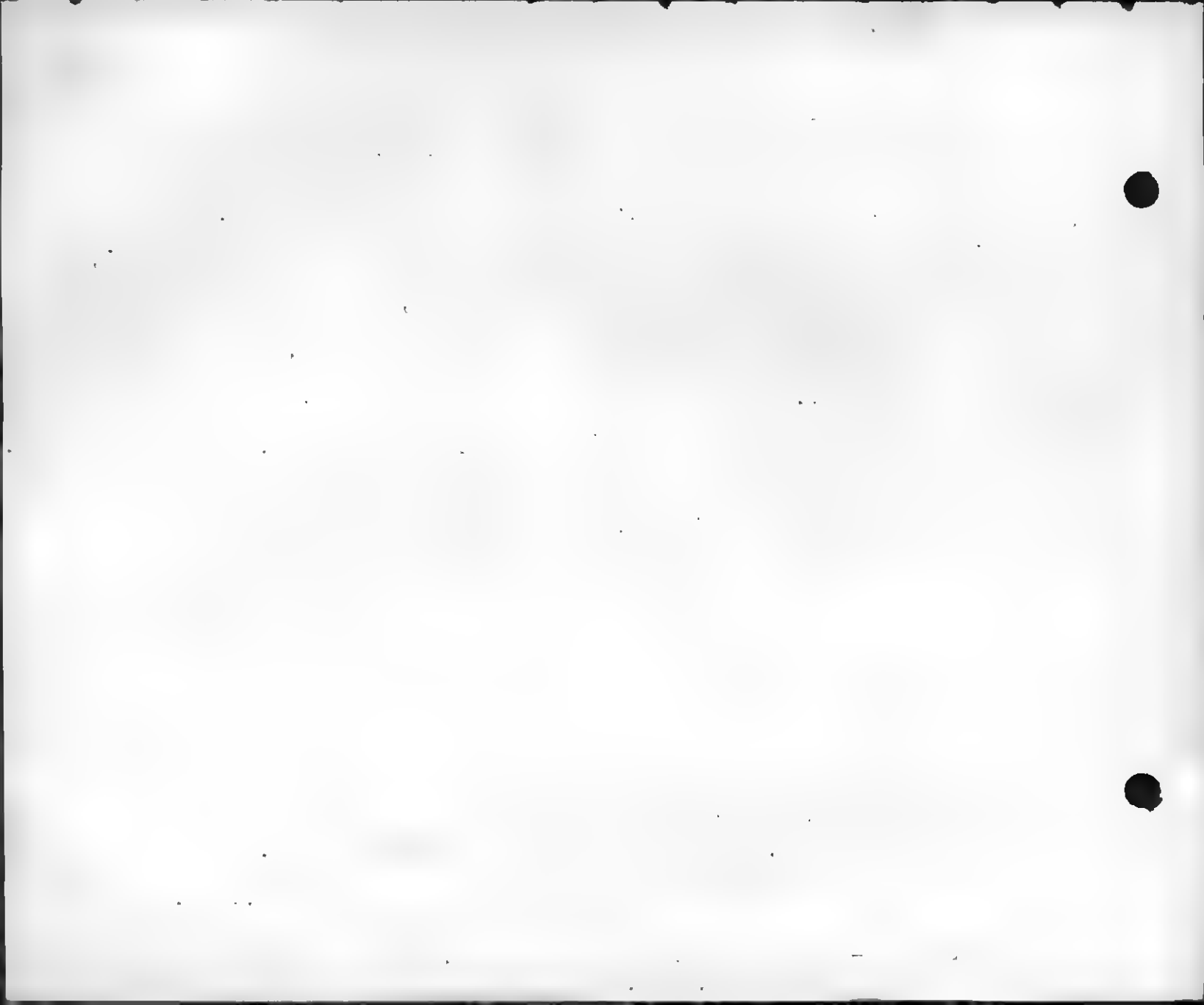


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VR AIS (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>06203</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>Item #13444 Film #3309 6/2/67</p> </div> <div> <p>06199</p> <p>CERTIFICATE OF DEATH</p> <p>Item 2 Film 0349 6/2/67</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY Baltimore						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baptist Home of Maryland						d. STREET ADDRESS 1606 E. Lanvale Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Annie			First		Middle		Last		4. DATE OF DEATH Month May Day 19 Year 1967		
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 8, 1864		9. AGE (In years last birthday) 103 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Richmond, Va.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Clement C. Tinsley Albert P. Bennett						14. MOTHER'S MAIDEN NAME Margaret Glazebrook Clement C. Tinsley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.		17. INFORMANT Baptist Home of Md. Owings Mills, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure DUE TO (b) Arteriosclerotic C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Senility										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 60 , to May 15, 1967 , that (I) (we) last saw the deceased alive on May 14, 1967 , and that death occurred at 11 M, from the causes and on the date stated above.											
22a. SIGNATURE Dr. M. Paul Byerly						22b. DATE SIGNED		22c. ADDRESS 5820 York Rd.			
22c. PHYSICIAN'S NAME (Type) Dr. M. Paul Byerly				22d. ADDRESS		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF 5/23/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore		23d. LOCATION (City, town or county) (State) Balto., Md.			
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home						ADDRESS 6500 York Rd.		25a. REC'D BY REGISTRAR MAY 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
Balto., Md. 21212											



7-1

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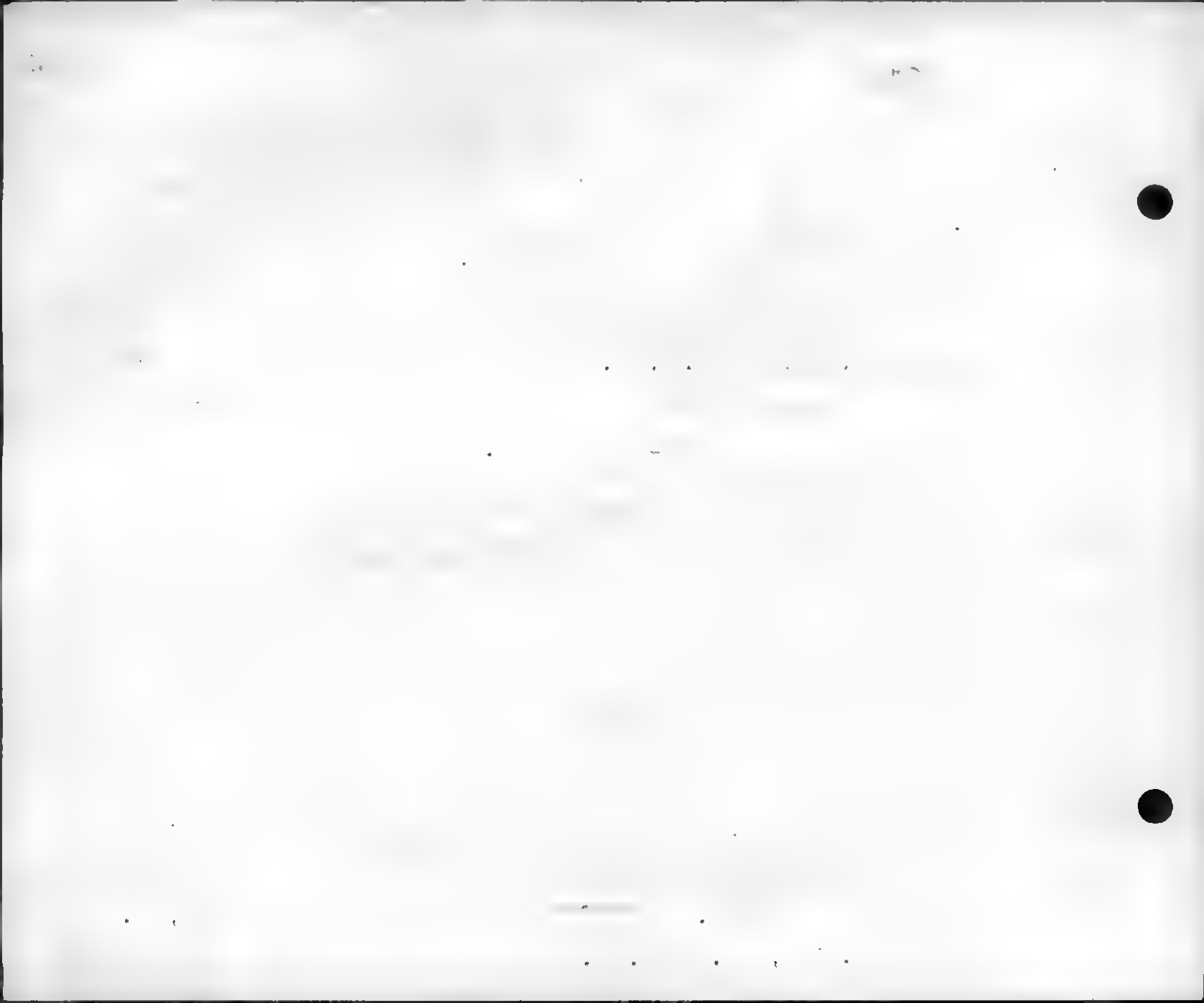
VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06200

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 45yrs.		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 2717 Westfield Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Sarah E. Bewick		4 DATE OF DEATH Month Day Year 5 21 19 67		5 SEX Female		6 COLOR OR RACE White	
7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 1/8/1899		9 AGE (In years last birthday) yrs 68		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		10b. KIND OF BUSINESS OR INDUSTRY G. & E. Co.		11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Jennings				14. MOTHER'S MAIDEN NAME Catherine Gorman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-12-9881A		17. INFORMANT Mrs. Dorothea Horsey		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Renal insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) terminal stage of multiple myeloma DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic pneumonia						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 4 (this hospital) attended the deceased from 4/25/1967 , to 5/21/1967 , that 4 (we) last saw the deceased alive on 5/21/1967 , and that death occurred at 8:25 PM , from causes and on the date stated above							
22a. SIGNATURE 				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED May 22, 1967	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.				22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/25/67.		23c. NAME OF CEMETERY OR CREMATORY Rackwood Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR DATE MAY 24 1967		25b. REGISTRAR'S SIGNATURE 	

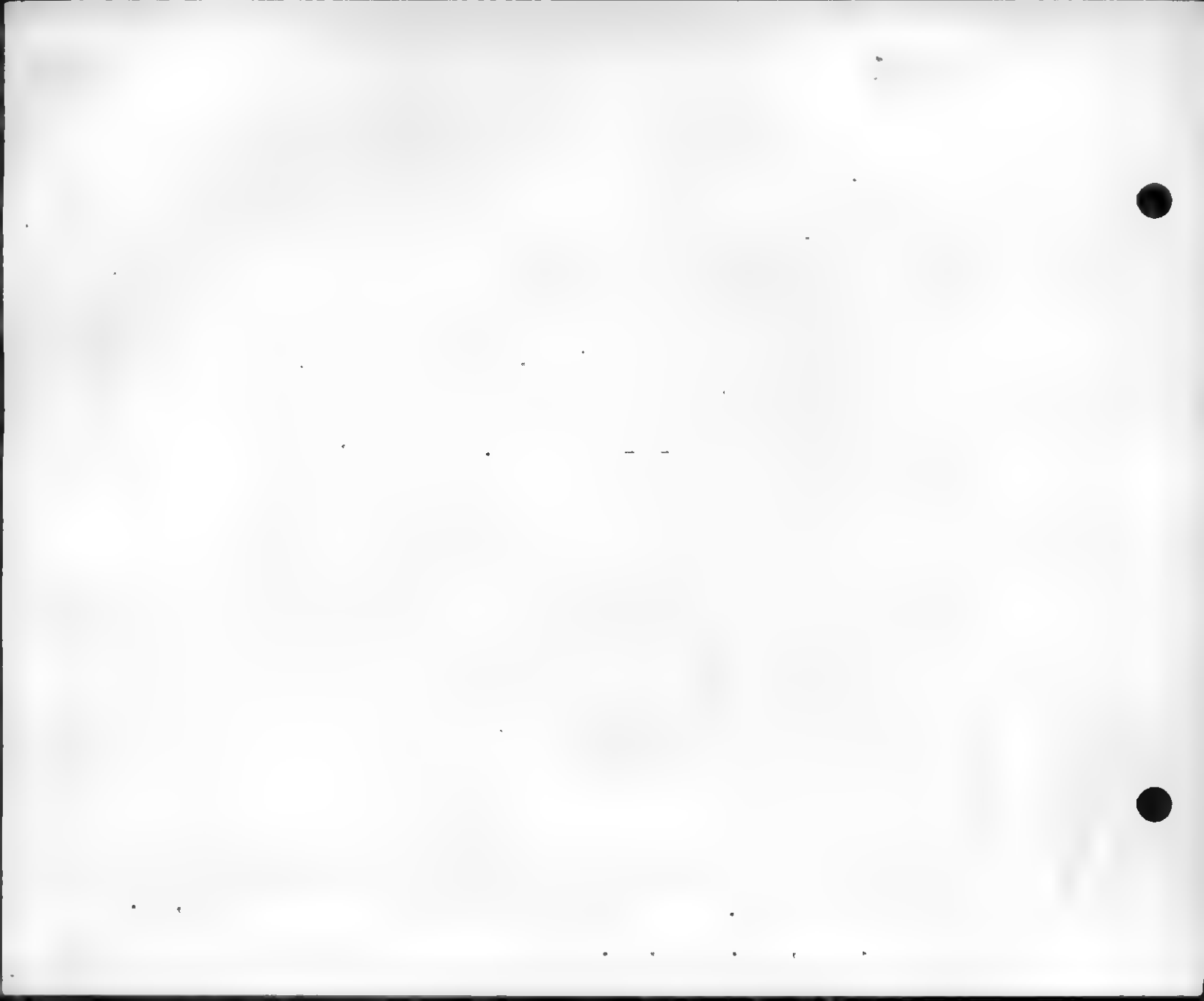


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06211			CERTIFICATE OF DEATH				06201		
1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY —				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital					d. STREET ADDRESS 5853 Belair Road			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Henry Last Bilzer					4. DATE OF DEATH Month May Day 21 Year 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 9-22-01		9. AGE (In years last birthday) yrs 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Martin Co.		11 BIRTHPLACE (County & State, or foreign country) Baltimore, Md.			12 C ITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Edward Bilzer					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-01-9329A		17. INFORMANT Mrs. Mary Bilzer			Address (Same)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute myocardial infarction. X X X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Occlusion, left coronary artery. X X X (c) Arteriosclerosis, generalized.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus.								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that XX (this hospital) attended the deceased from April 8, 19 67 , to May 21, 19 67 , that XX (we) last saw the deceased alive on May 21, 19 67 , and that death occurred at 4:55 AM , from causes and on the date stated above.									
22a. SIGNATURE <i>Manuel S. Cockburn</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED May 21, 1967	
22c. PHYSICIAN'S NAME (Type) Manuel S. Cockburn, M.D.				22d. ADDRESS 7620 York Road, Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/24/67.		23c. NAME OF CEMETERY OR CREMATORY Holy redeemer Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR DATE MAY 22 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

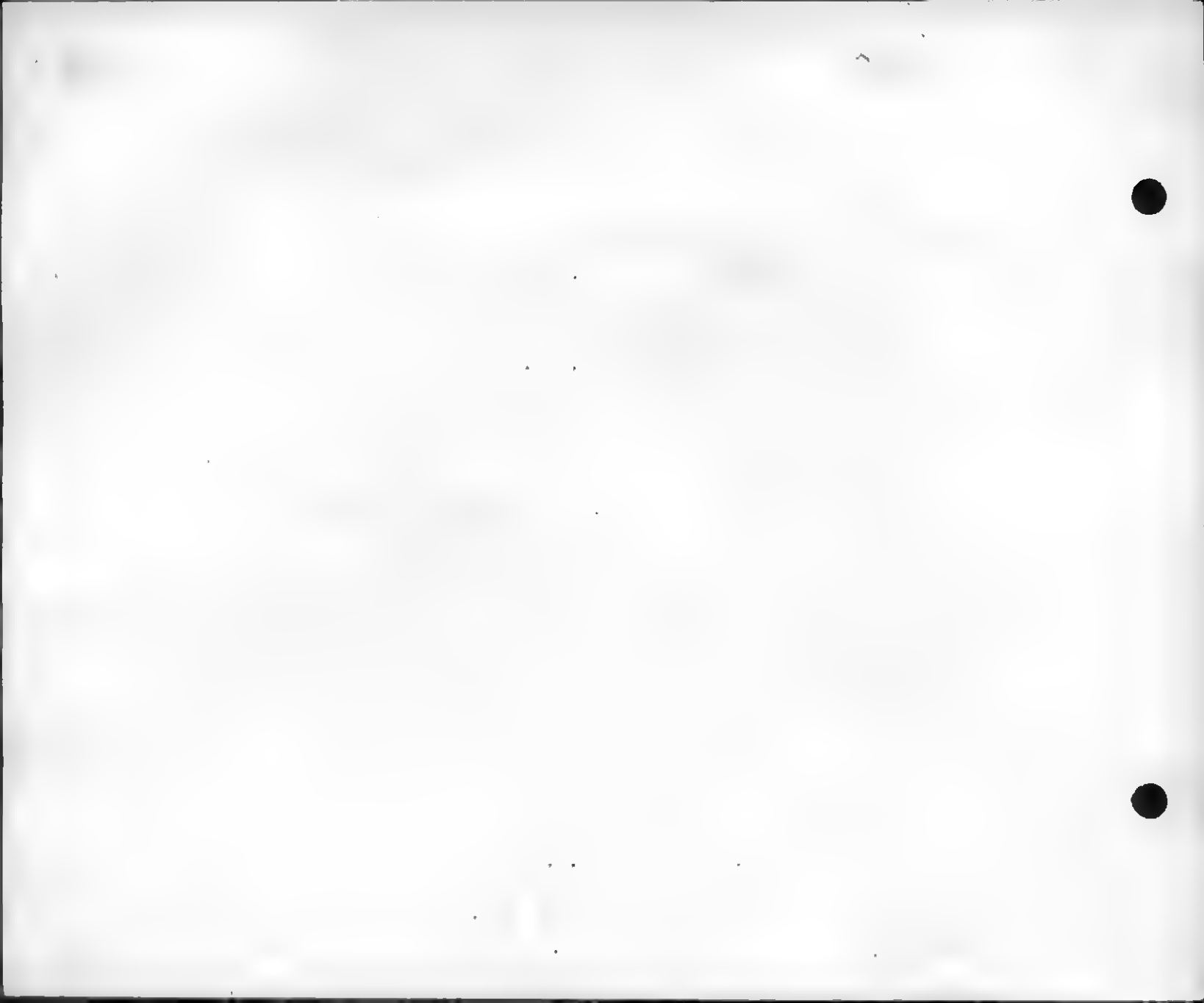
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06212

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00202

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Pennsylvania b. COUNTY McDonald,			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN b.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McDonald,		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center				d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First WILLIAM Middle A. Last BISH				4 DATE OF DEATH Month May Day 4 Year 19 67			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/28/16		9 AGE (In years last birthday) 51 yrs	10 UNDER 1 YEAR Months 5 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY GENERAL CON. CO.		11 BIRTHPLACE (State or foreign country) PENNSYLVANIA		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME CIARENCE BISH				14 MOTHER'S MAIDEN NAME ETHEL WITSON			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO		17 INFORMANT MARY BISH, MCDONALD, PA.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Dissecting aneurysm of aorta 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town or county)		22. DATE SIGNED May 5, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/8/67		23c. NAME OF CEMETERY OR CREMATORY MIDIVAY CEM.		23d. LOCATION (City or town) (County) (State) MIDIVAY, PA.	
24 FUNERAL DIRECTOR HOWARD H. HUBBARD 4107 WILKENS AVE. 21229				25a. REC'D BY REGISTRAR MAY 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

36213

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE IN PINES CONV. HOME</u>		d. STREET ADDRESS <u>4457 SCOTIA RD</u>	
3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>STREAGLE</u> Last <u>Blake</u>		4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/8/88</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GLOUCESTER, VA.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EUGENE STREAGLE</u>		14. MOTHER'S MAIDEN NAME <u>MAUDE DUNSTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>217200160</u>	
17. INFORMANT <u>HARRY EMERSON</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>generalized abdominal carcinoma</u> DUE TO <u>carcinoma of transverse colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Unknown.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 Mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to <u>May 21, 1967</u> , that I last saw the deceased alive on <u>May 9, 1967</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bradley Laugharty</u> M.D. <u>12647 Francis Ave Baltimore Md</u>		DATE SIGNED <u>5-21-67</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/24/67</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BELLAMY CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>GLOUCESTER, VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>BRIDGES FUNL. HOME</u>		ADDRESS <u>GLOUCESTER, VA.</u>	
24a. REG'D BY REGISTRAR <u>Charles Judge</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAY 22 1967</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

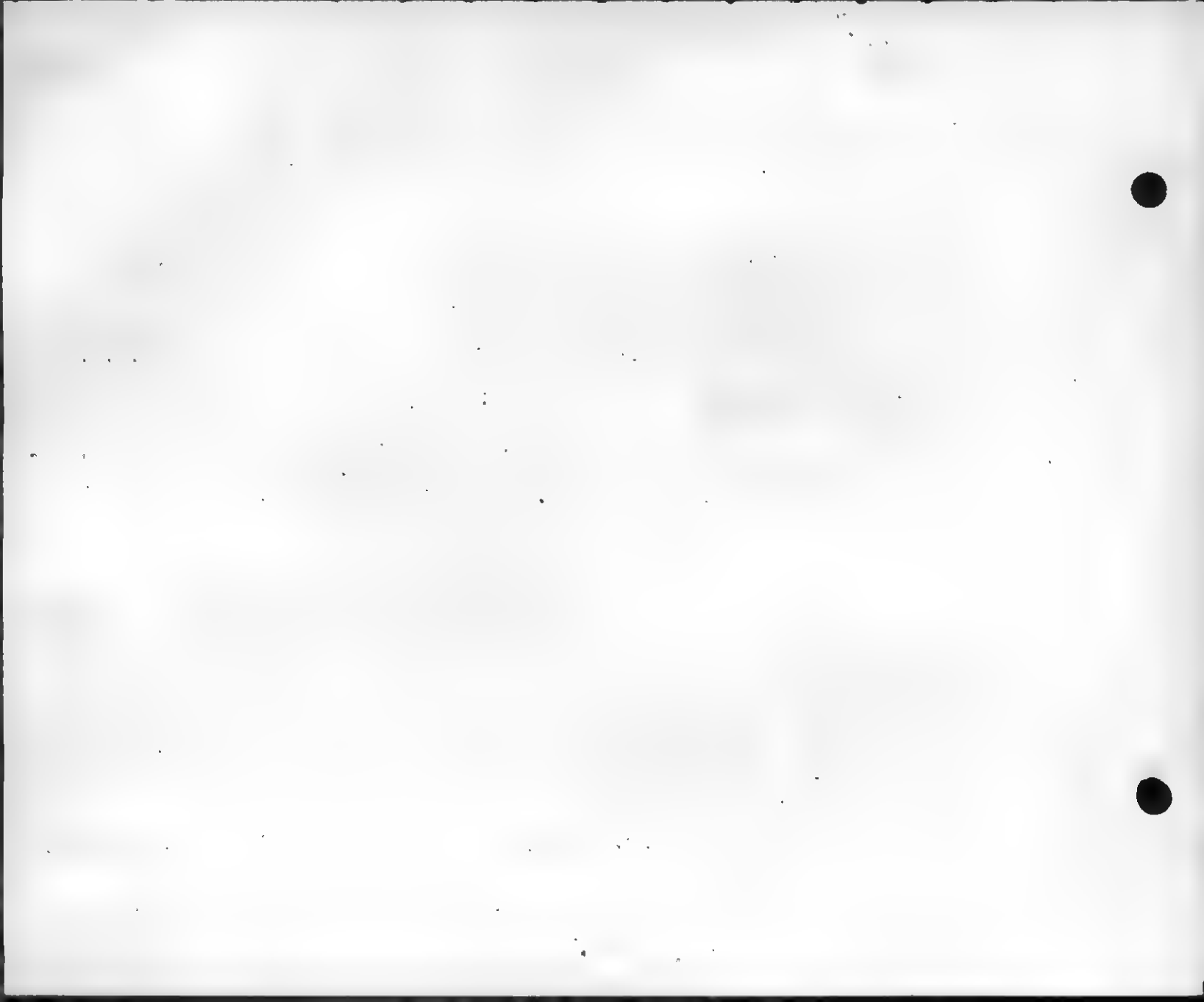


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
36214 CERTIFICATE OF DEATH 06204

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Govans) Baltimore 12				c. LENGTH OF STAY IN 1b 26 yrs			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 322 Regester Avenue				d. STREET ADDRESS 322 Regester Avenue			
3. NAME OF DECEASED (Type or print) First ALICE Middle MONA Last BOLLINGER				4. DATE OF DEATH Month May Day 17 , Year 1967			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 20, 1908	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 5 Days 17 Hours 17 Min.		IF UNDER 24 HRS. Months 5 Days 17 Hours 17 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				11. BIRTHPLACE (County & State, or foreign country) Carroll County			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles L. Brauning				14. MOTHER'S MAIDEN NAME Mollie Shipley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) —				16. SOCIAL SECURITY NO. —			
17. INFORMANT J. Wilbur Bollinger				Address 322 Regester Ave Baltimore 12, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute Bronchopneumonia DUE TO (b) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							INTERVAL BETWEEN ONSET AND DEATH 5 hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that (I) (this hospital) attended the deceased from May 15, 1967 to May 17, 1967 , that (I) (we) last saw the deceased alive on May 16, 1967 , and that death occurred at 10:45 PM , from the causes and on the date stated above.							
22a. SIGNATURE Theodore G. de Cuerdo				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 17, 1967	
22c. PHYSICIAN'S NAME (Type) Theodore G. de Cuerdo				22d. ADDRESS #23 Thornhill Rd. Lutherville-Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 5/20/67		23c. NAME OF CEMETERY OR CREMATORY Providence Cemetery		23d. LOCATION (City, town or county) (State) Finksburg RD, Maryland	
24. FUNERAL DIRECTOR J. E. Myers Jr., Westminster, Md.				25a. REC'D BY REGISTRAR MAY 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06215

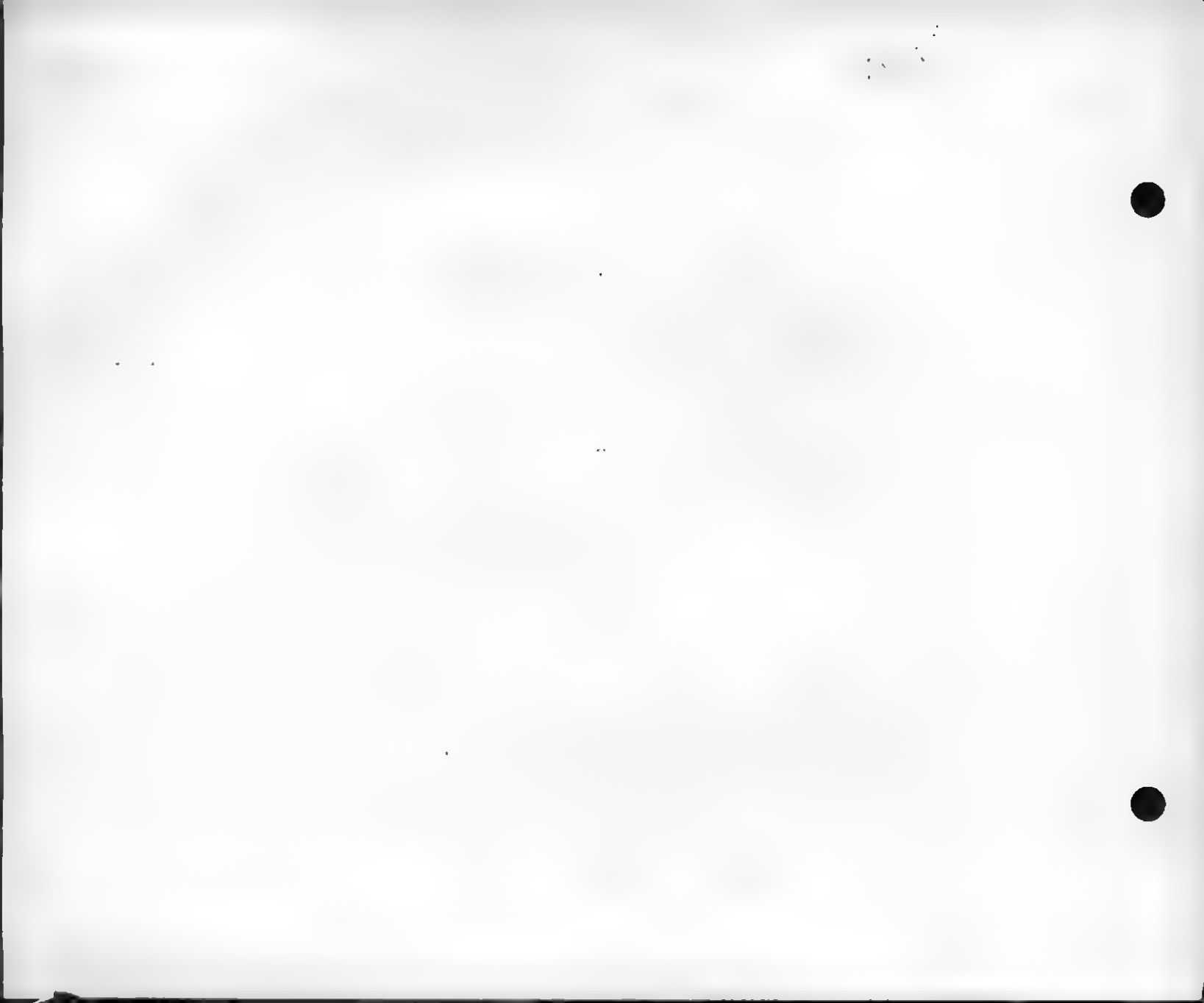
CERTIFICATE OF DEATH

Items #8, 9, 16, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

05205

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville c. LENGTH OF STAY IN 1b 2yr7mth18dys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2 USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1500 West Baltimore Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle G. Last Bookhultz		4. DATE OF DEATH Month MAY Day 24 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1893
9. AGE (In years last birthday) 72 1/2 yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. COUNTRY OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 215-03-2622	
17. INFORMANT		Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from Oct. 6, 1964 to 5-24, 1967 , that (I) (we) last saw the deceased alive on 5-24, 1967 , and that death occurred at 6:19 P.M. from causes and on the date stated above.			
22a. SIGNATURE Morris Meiller M.D.		22b. DATE SIGNED 5/24/67	
22c. PHYSICIAN'S NAME (Type) MORRIS MEILLER, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF May 22, 1967	
23c. NAME OF CEMETERY OR CREMATORY Harold Heintz Cemetery		23d. LOCATION (City or town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Farley - Cavanaugh		25a. REC'D BY REGISTRAR 6601 Frederich	
25b. REGISTRAR'S SIGNATURE Charles Jones		DATE MAY 29 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06216

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

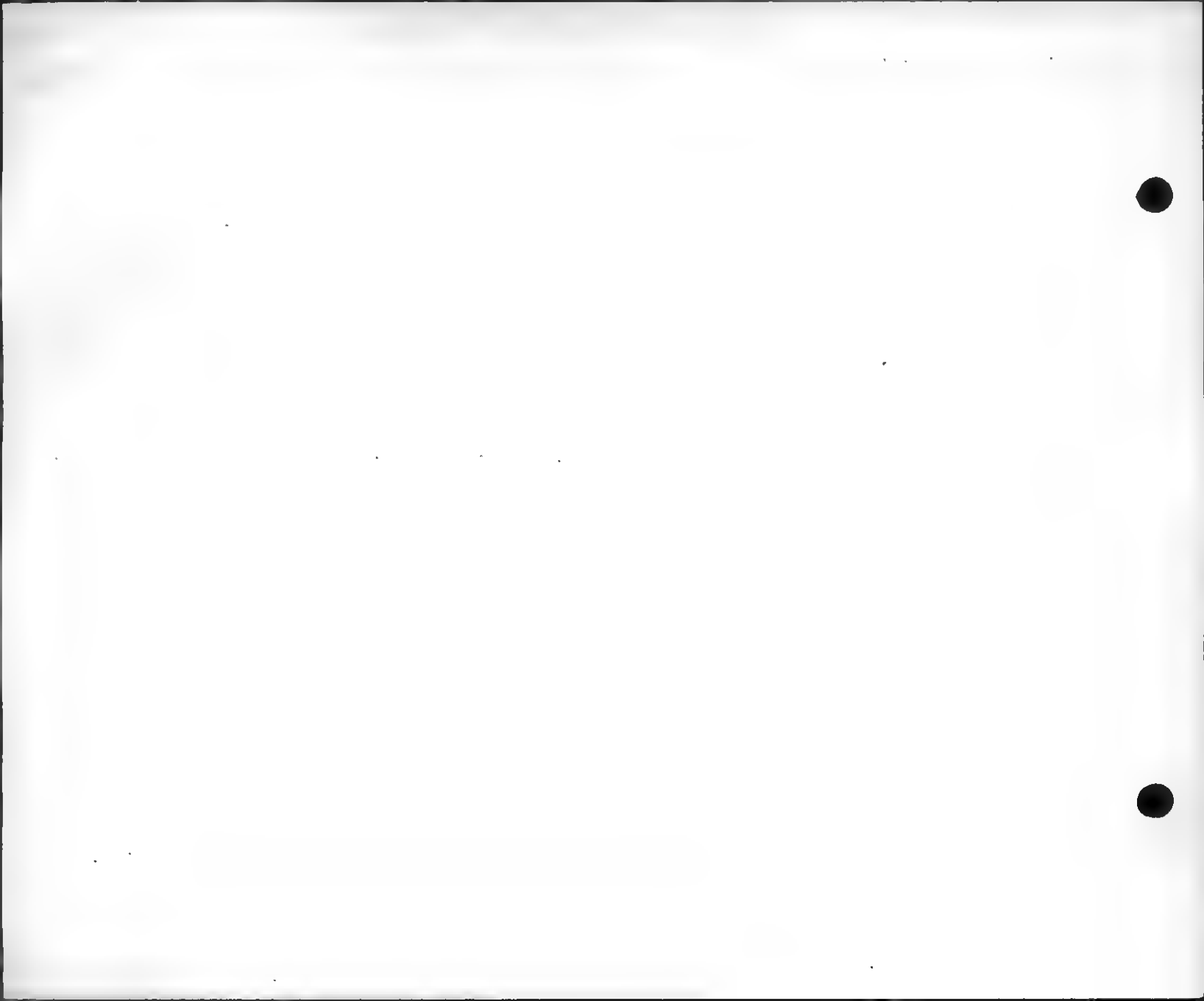
06206

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MD. b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c LENGTH OF STAY IN Tb	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PINE RIDGE GOLF COURSE		d STREET ADDRESS 4312 BARRINGTON RD. 2122 9	
3 NAME OF DECEASED (Type or print) LOUIS Charles BORCHERDING, Sr.		4 DATE OF DEATH MAY 30 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6/7/03
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Proctor & Gamble	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Louis C. Borcherdig, Sr.		14 MOTHER'S MAIDEN NAME Bertha Kuhlow	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, for unknown) No (If yes give war or dates of service)		16 SOCIAL SECURITY NO 214-01-8979	
17 INFORMANT Mrs. Helen R. Borcherdig Barrington Rd.		Address 4312	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William A. Pillsbury M.D.		22. DATE SIGNED 5/30/67	
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or locality) Timonium, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 6/2/67	23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d LOCATION (City or town) (County) (State) Baltimore, Maryland
24 FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Ave. 21229		25a REC'D BY REGISTRAR JUN 2 1967	
		25b REGISTRAR'S SIGNATURE [Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

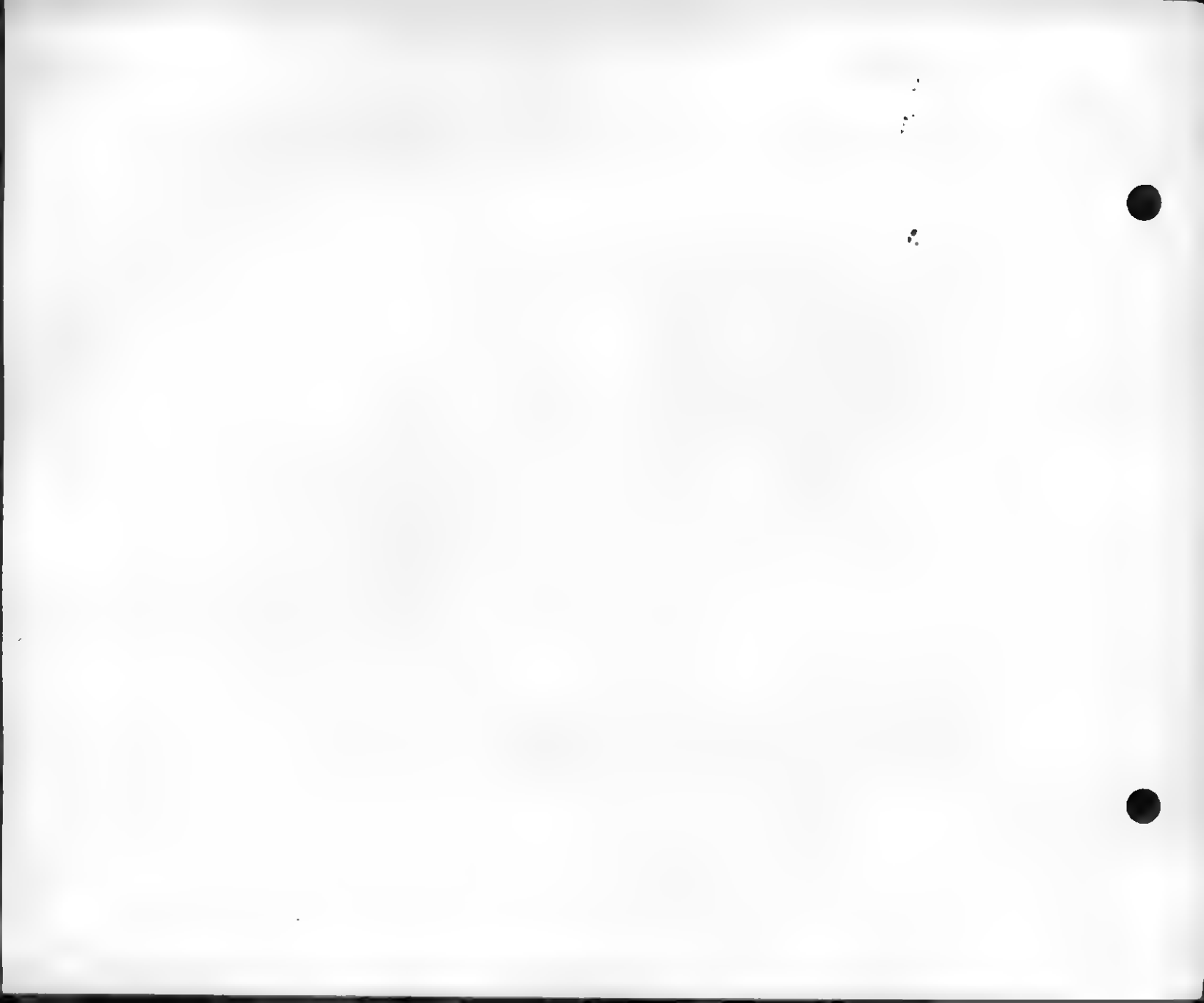
06217

CERTIFICATE OF DEATH

06208

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUMMIT HOME</u>		d. STREET ADDRESS <u>5920 JOHNNYCAKE RD</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>JOHN BERNARD BREITENBACH</u>		4 DATE OF DEATH Month Day Year <u>5/19 1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/4/91</u>
9 AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B.Y.O. R.R.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>RUDOLPH BREITENBACH</u>		14 MOTHER'S MAIDEN NAME <u>LOUISE HENNEGIN</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO	
17 INFORMANT <u>FRANKLIN R. BREITENBACH</u>		Address	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <u>CARCINOMA PLEURA, LEFT</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 MOS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/6</u> , 19 <u>66</u> to <u>5/9</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>5/8</u> , 19 <u>67</u> , and that death occurred at <u>9:20</u> M. from causes and on the date stated above.			
22a. SIGNATURE <u>Thos E Roach</u>		22b. DATE SIGNED <u>5/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOS E ROACH</u>		22d. ADDRESS <u>5550 BALTO/VATE LINE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOUNDON PARK</u>	23d. LOCATION (City or town) (County) (State) <u>BALTO MD</u>
24 FUNERAL DIRECTOR <u>E.S. MALNABB</u>		25a. REC'D BY REGISTRAR <u>21228</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 15 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

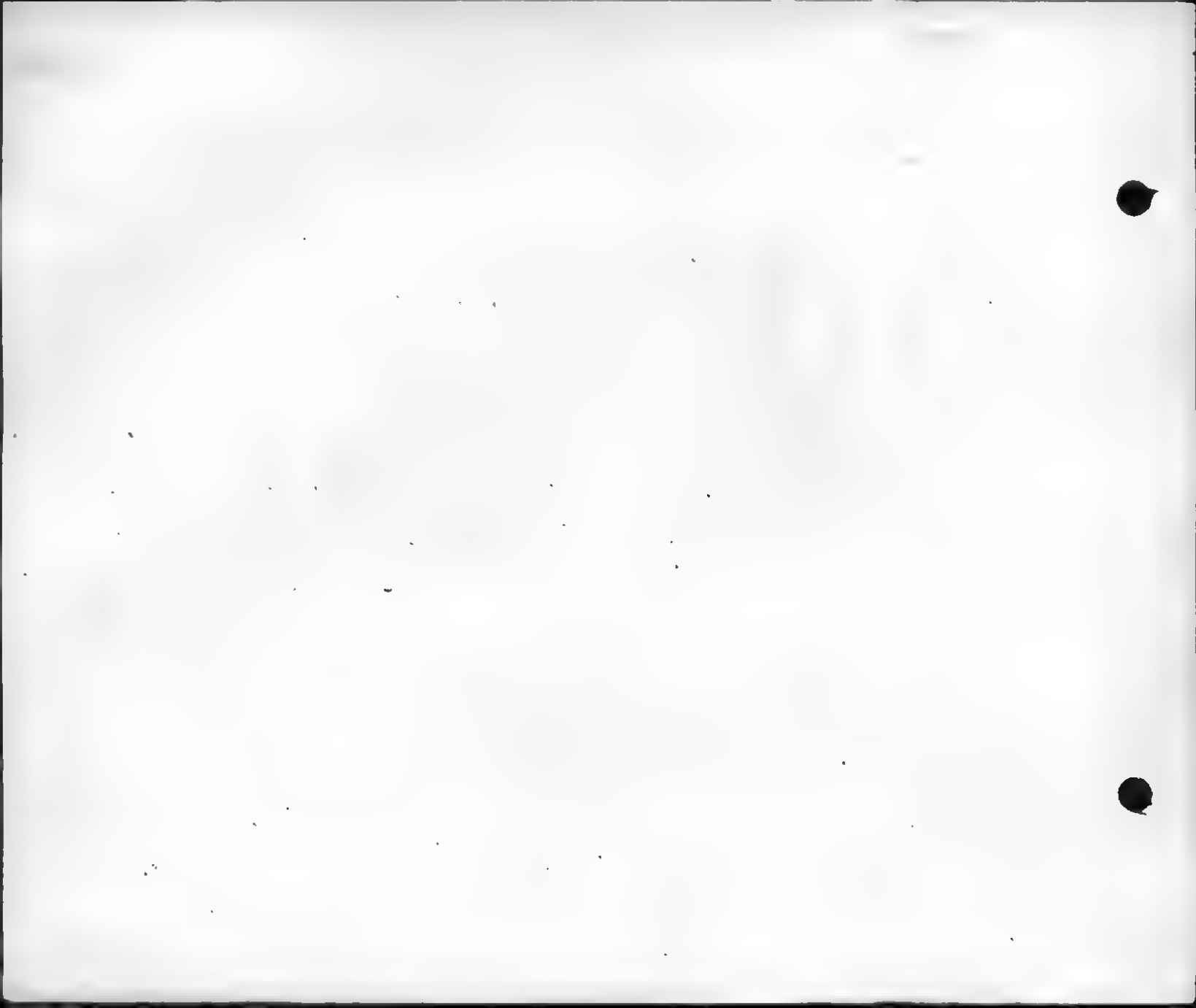
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06218

CERTIFICATE OF DEATH

Reg. Dist. No. 05209

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Rosedale</i> c. LENGTH OF STAY IN 1b <i>10 years</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1328 Evering Avenue</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Rosedale</i> d. STREET ADDRESS <i>1328 Evering Avenue</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Christine G.</i> Middle <i>Brewer</i> Last <i></i>		4. DATE OF DEATH Month <i>May</i> Day <i>20</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 1, 1907</i>
9. AGE (In years last birthday) <i>59</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Joseph Levy</i>	
14. MOTHER'S MAIDEN NAME <i>Elizabeth</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>218 09 1275</i>		17. INFORMANT Address <i>Chrystelle Brockmeyer 2220 Jaycee Dr. Joppa, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>260X Acute Myocardial failure</i> DUE TO (b) <i>Arteriosclerotic Cardio-Vascular disease</i> DUE TO (c) <i>Unstable Angina pectoris</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>10 yrs</i> <i>15 yrs</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i></i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	
20f. (City or town) (County) (State) <i></i>		21. I certify that I attended the deceased from <i>May 1, 1967</i> to <i>May 20, 1967</i> , that I last saw the deceased alive on <i>May 20, 1967</i> and that death occurred at <i>1 A.M.</i> from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>G. M. Baumgardner</i> M.D.		ADDRESS (Street, city or town, state) <i>Baltimore 21206</i>	
PHYSICIAN'S NAME (Type) <i>G. M. BAUMGARDNER</i>		DATE SIGNED <i>5/26/67</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 22, 1967</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Philip G. Cook</i>		ADDRESS <i>1211 Chesaco Avenue</i>	
24a. REC'D BY REGISTRAR <i>Charles Judge</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>MAY 22 1967</i>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-10. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

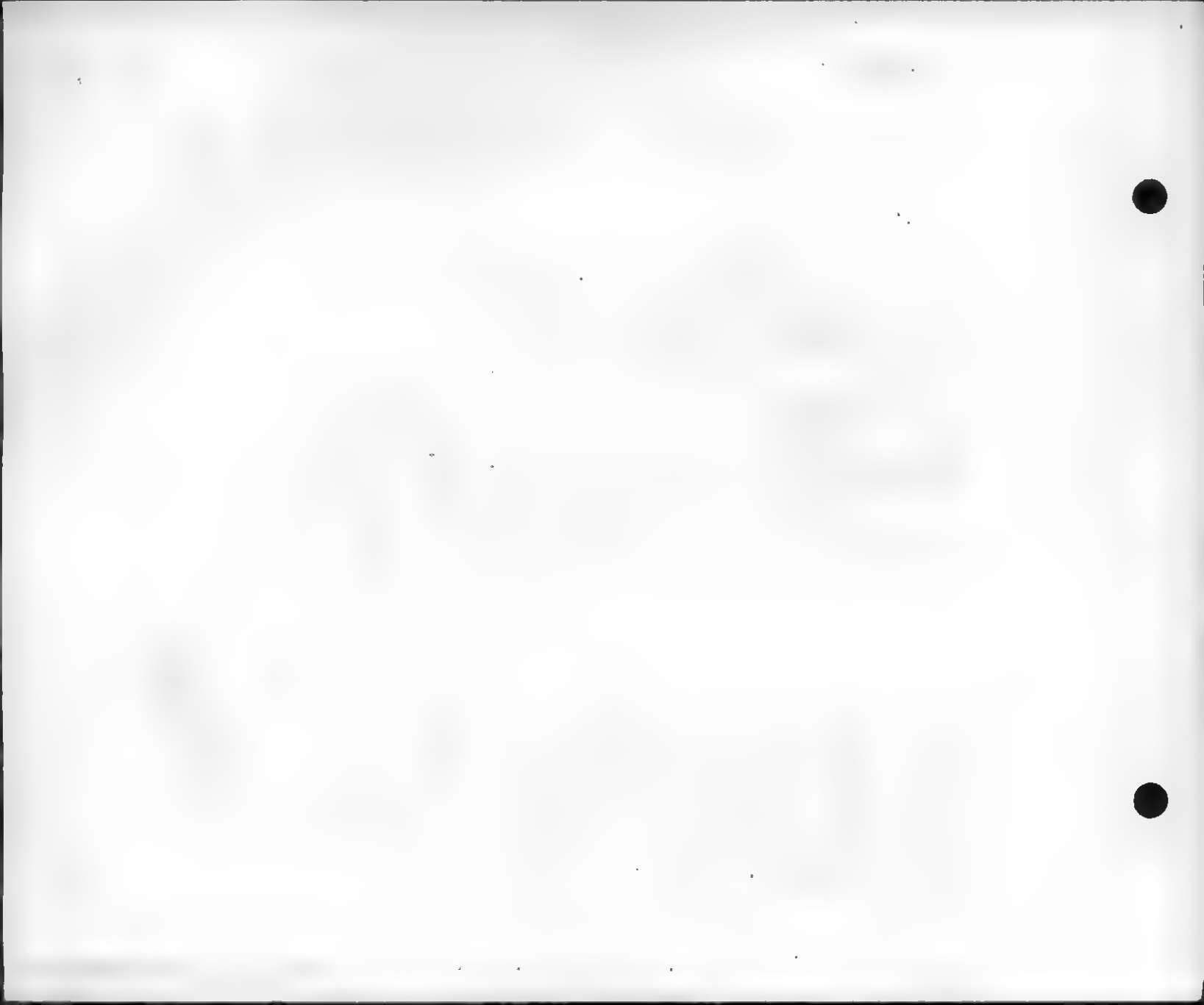
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06213

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06210

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex c. LENGTH OF STAY IN b Essex d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Essex House Tavern				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex d. STREET ADDRESS 446 Eastern Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HERBERT RICHARD BRODNICK				4. DATE OF DEATH Month Day Year 5 3 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 36 yrs	9. AGE (in years last birthday) 36 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10b. KIND OF BUSINESS OR INDUSTRY EASTERN TAXI CAB CO.		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BENJAMIN BRODNICK				14. MOTHER'S MAIDEN NAME ELIZABETH FISHER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO UNKNOWN		17. INFORMANT Address MR. LOUIS BRODNICK, 3921 BANCROFT ROAD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cor pulmonale 287V DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Obesity - (Pickwickian Syndrome) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I a item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 5-3-67	
EXAMINER'S NAME (Type)		ADDRESS		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/4/67	23c. NAME OF CEMETERY OR CREMATORY OBER SHALOM		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		25a. REC'D BY REGISTRAR MAY 8 1967	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.				25b. REGISTRAR'S SIGNATURE Charles Judge			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

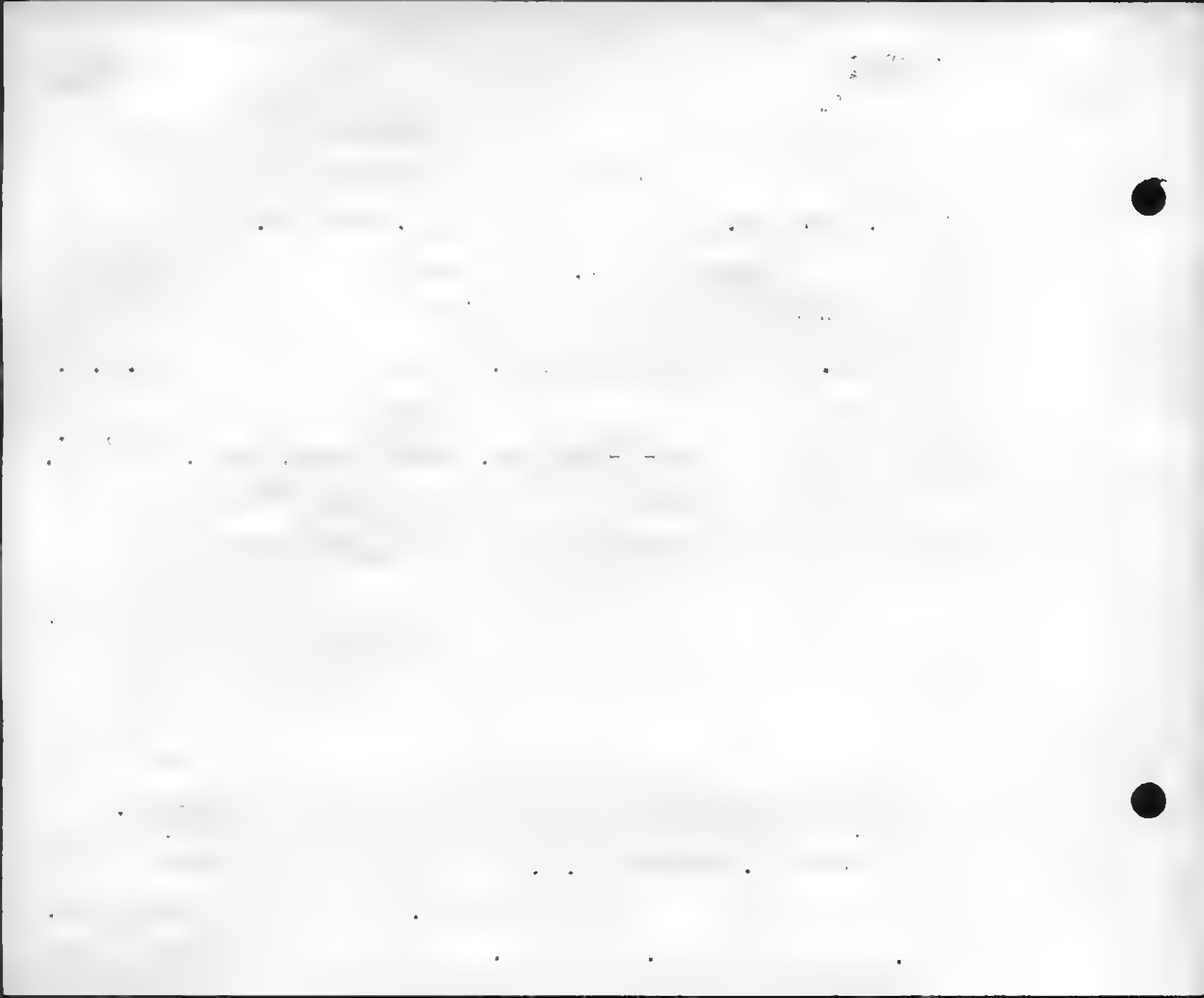
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06220

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06211

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Baltimore		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere		c LENGTH OF STAY IN It 21 Years		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2523 S. Snyder Ave.			d STREET ADDRESS 2523 S. Snyder Ave.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Venton Middle J. Last Brooks			4 DATE OF DEATH Month May Day 16 Year 1967		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/1/15	9 AGE (In years last birthday) 52 yrs	10 UNDER 1 YEAR Months Days Hours M n
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scale Dept.		10b KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11 BIRTHPLACE (State or foreign country) Virginia	
12 CITIZEN OF WHAT COUNTRY? U. S. A.					
13 FATHER'S NAME David Brooks			14 MOTHER'S MAIDEN NAME Clevie Brooks		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 217-07-7081		17 INFORMANT (Wife) Mrs. Florence Brooks, 2523 S. Snyder Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Coarctation DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) Resection					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Alcoholism By History					19 WAS A TAPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Theodore C. Patterson M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		105 Main St. 22. DATE SIGNED	
EXAMINER'S NAME (Type) Theodore C. Patterson M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Dundalk,	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Maryland 5/16/67	
		Address (Street, city, town, or county)			
23a PLURAL CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 5/19/67	23c NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d LOCATION (City or town) (County) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a REC'D BY REGISTRAR MAY 18 1967		25b REGISTRAR'S SIGNATURE Theresa A. Duda	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06221

CERTIFICATE OF DEATH

06212

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 64 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1408 N. MOUNT STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First FRANK Middle VERNON Last BROWN				4 DATE OF DEATH Month MAY Day 5 Year 19 67			
5 SEX MALE	6 COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 6, 1907		9 AGE (In years last birthday) yrs 59	10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RIGGER		10b. KIND OF BUSINESS OR INDUSTRY SHIP YARD		11 BIRTHPLACE (County & State, or foreign country) LITTLETON, N. C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK BROWN				14. MOTHER'S MAIDEN NAME MARTHA HAWKINS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		6 SOCIAL SECURITY NO 213 09 12 91		17 INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EDEMA 5811 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LAENNEC'S CIRRHOSIS DUE TO (c) CHRONIC ALCOHOLISM						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HEART DISEASE (HYPERTROPHY) UNKNOWN ETIOLOGY						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from 3/2/67 , 19____, to 5/5/67 , 19____, that (2) (we) last saw the deceased alive on 5/5/67 , 19____, and that death occurred at 6:30AM , from causes and on the date stated above							
22a. SIGNATURE <i>Neilon Neilson</i> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/5/67	
22c. PHYSICIAN'S NAME (Type) NEILON NEILSON, N. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-9-67		23c. NAME OF CEMETERY OR CREMATORY Baltimore NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>Theron B. Bailey</i>				ADDRESS KELSON FUNERAL HOME		25a. REC'D BY REGISTRAR DATE MAY 9 1967	
						25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

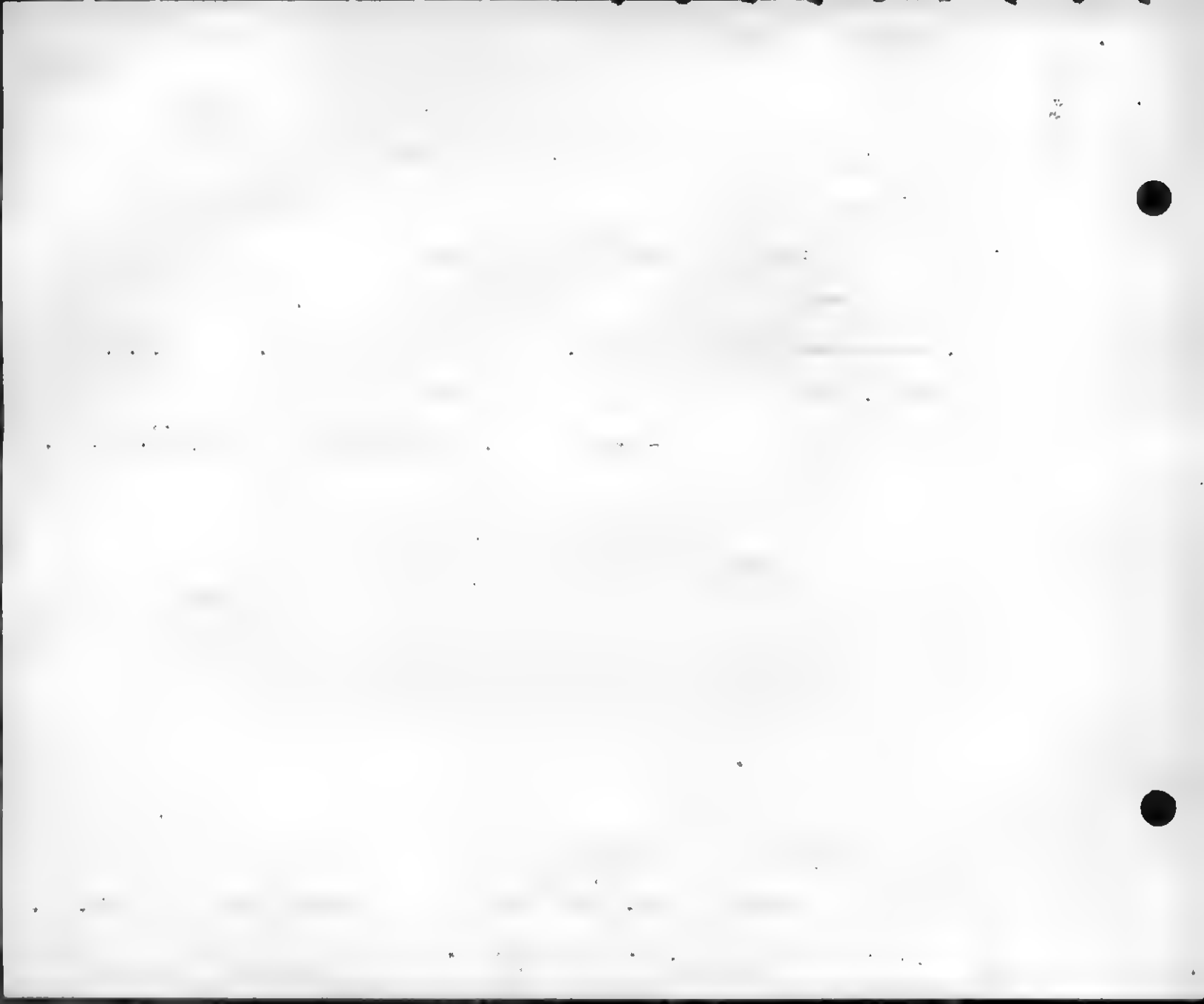
VR A15 (4)
2DM 1/65

26222

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06213

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN ID 16 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 133 Pleasant Hill Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills d. STREET ADDRESS 133 Pleasant Hill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Millie Middle Catherine Last Brown		4. DATE OF DEATH Month MAY Day 14 Year 1967	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/6/1880	
9. AGE (in years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 11 Days 14 Hours 14 Min. 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Housework-Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home.	
11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David W. Bair		14. MOTHER'S MAIDEN NAME Anna Mary Myers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 196-16-9926	
17. INFORMANT Mrs. Claude H. Miller		18. ADDRESS 133 Pleasant Hill Road, Owings Mills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC C.V. DISEASE WITH (c) CARDIAC DECOMPENSATION		INTERVAL BETWEEN ONSET AND DEATH 24 HRS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE , 1951, to MAY 14, 1967 , that (I) (we) last saw the deceased alive on MAY 13 1967 , and that death occurred at 3:50 PM , from the causes and on the date stated above.			
22a. SIGNATURE Martin E. Strobel		22b. DATE SIGNED MAY 14, 1967	
22c. PHYSICIAN'S NAME (Type) MARTIN E. STROBEL		22d. ADDRESS 48 MAIN ST. REISTERSTOWN MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/17/67	
23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION (City, town or county) (State) Silver Run, Carroll Co. Md.	
24. FUNERAL DIRECTOR Richard A. Little		25a. REC'D BY REGISTRAR Littlestown, Pa.	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE MAY 16 1967	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

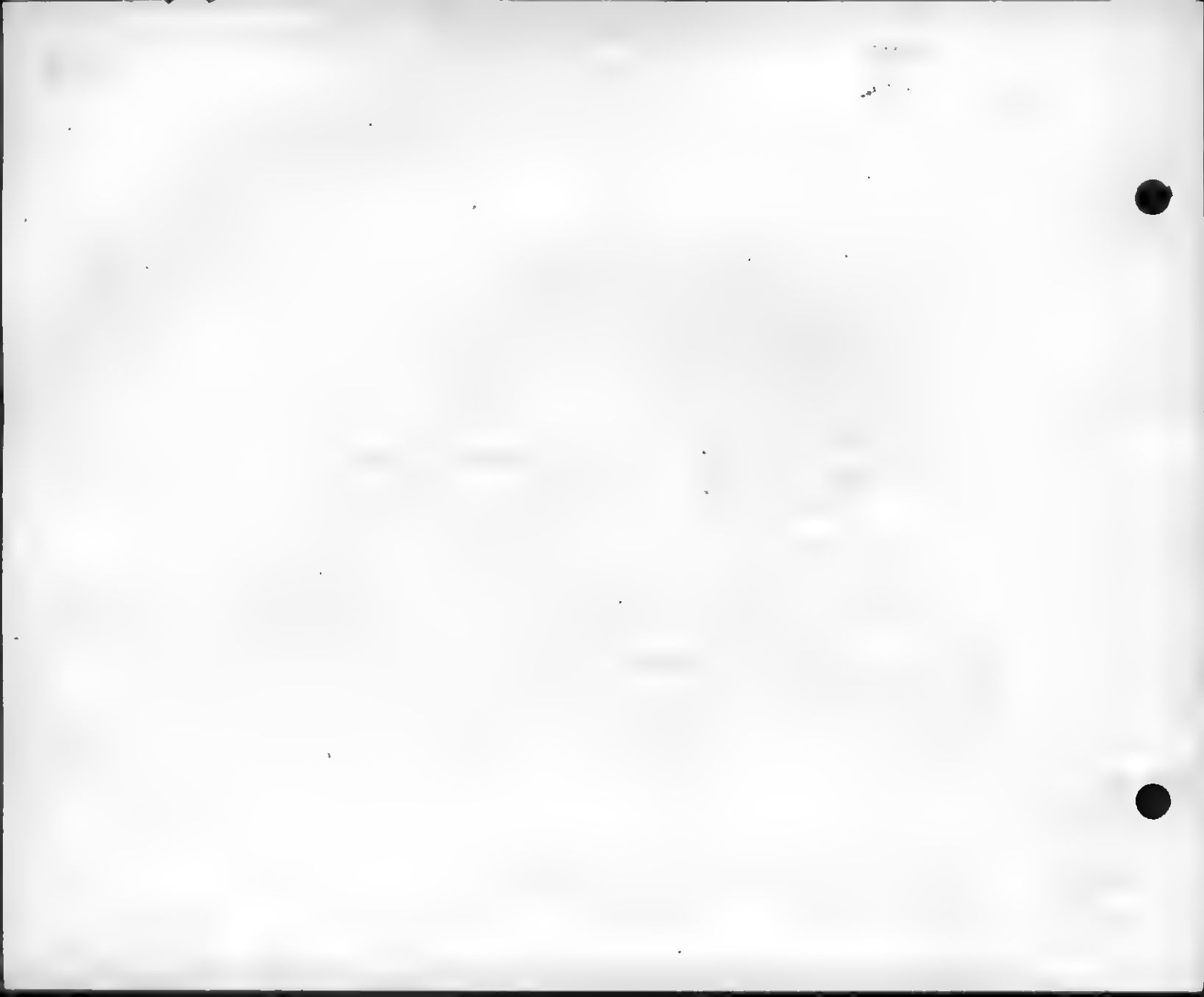
CERTIFICATE OF DEATH

06223

06214

1 PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Wilson</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mount Wilson State Hospital</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2027 Sinclair Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>WILLIE</u> First <u>BROWN</u> Middle Last 5 SEX <u>M</u> 6 COLOR OR RACE <u>Negro</u> 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH <u>12.12.1917</u> 9 AGE (In years last birthday) <u>49</u> yrs 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> 10b K NO. OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (County & State, or foreign country) <u>Georgia</u> 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>LEMMETT BROWN</u> 14 MOTHER'S MAIDEN NAME <u>EMMA BUTLER</u> 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16 SOCIAL SECURITY NO <u>264-05-6125</u> 17 INFORMANT <u>Records, Mount Wilson State Hospital</u> Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac tamponade</u> DUE TO <u>Pericardial effusion</u> Conditions, if any, wh. ch gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Pulmonary inflammatory infiltrate</u> (b) <u>7 days</u> (c) <u>2 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>5-8</u> , 19 <u>67</u> , to <u>5-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-10</u> , 19 <u>67</u> , and that death occurred at <u>5:10 AM</u> , from causes and on the date stated above. 22a SIGNATURE <u>Wm. Newcomer</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D., Superintendent</u> 22d ADDRESS <u>Mount Wilson, Maryland</u> 22b. DATE SIGNED <u>5.10.1967</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State)		24 FUNERAL DIRECTOR ADDRESS 25a REC'D BY REGISTRAR DATE <u>MAY 12 1967</u> 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

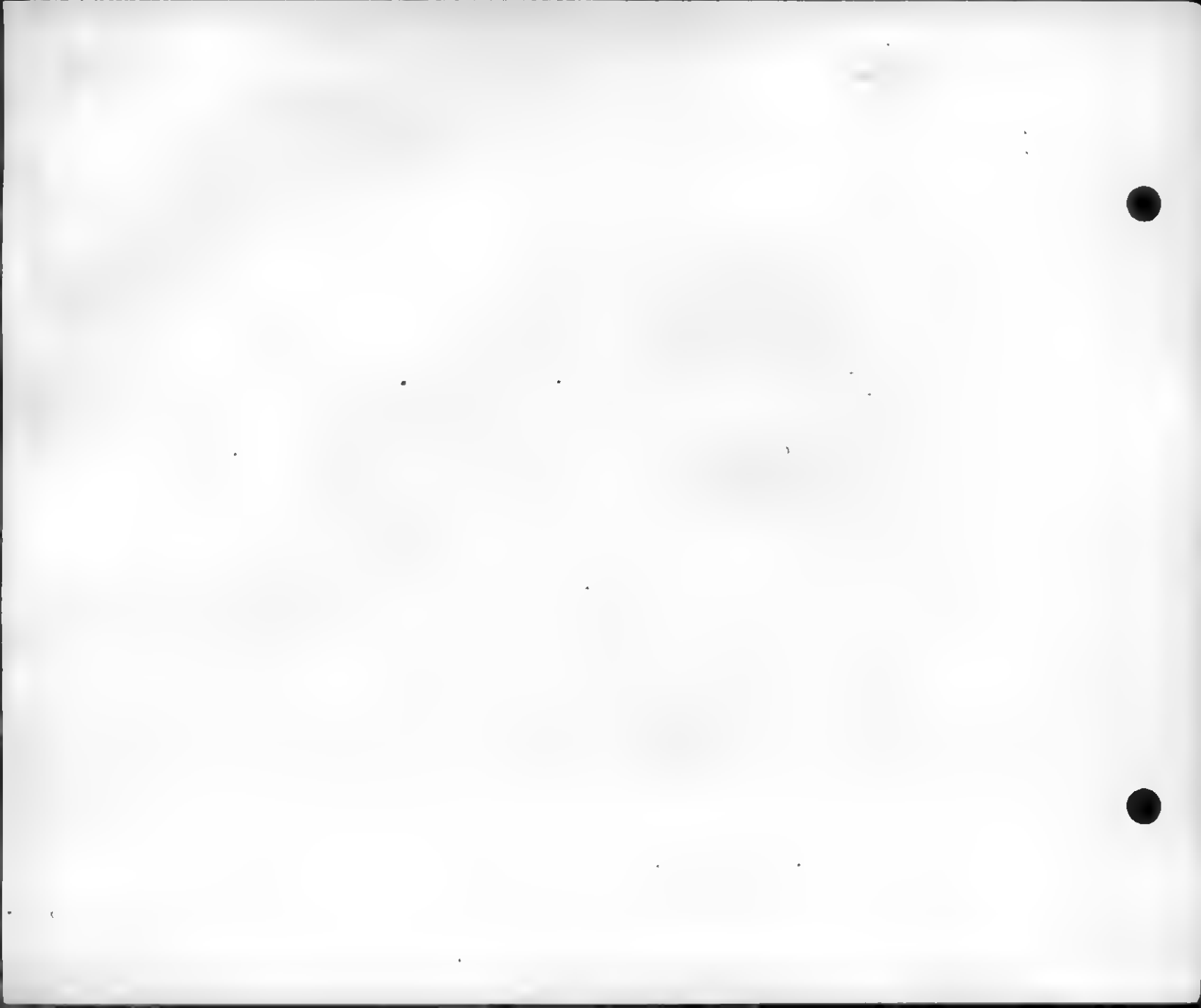
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06224

CERTIFICATE OF DEATH

00215

1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>BALTIMORE</u> 21212			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				c LENGTH OF STAY IN 1b <u>BALTIMORE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTO. MEDICAL CENTER.</u>				d. STREET ADDRESS <u>214 HOPKINS ROAD</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES MULLEN BURGEE</u>				4 DATE OF DEATH Month Day Year <u>MAY 16 19 67</u>			
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>CAUC.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-4-95</u>	9. AGE (In years last birthday) <u>71</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Electric Co.</u>		11 BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13 FATHER'S NAME <u>XXXXXXXXXXXX</u> Burgee				14. MOTHER'S MAIDEN NAME <u>XXXXXXXXXXXX</u> S. rah Hessong			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give unit or dates of service) <u>UNKNOWN</u> NO		16 SOCIAL SECURITY NO <u>216-01-9248</u>		17 INFORMANT Address <u>PT'S CHART Mrs. Evelyn P. Burgee</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Post-operative irreparable shock</u> DUE TO (c) <u>Ruptured abdominal aortic aneurysm.</u>						INTERVA. BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 16, 19 67</u> to <u>May 16, 19 67</u> , that (I) (we) last saw the deceased alive on <u>May 16, 19 67</u> , and that death occurred at <u>9:25 PM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>Robert W. Smith M.D.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>5-16-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Robert W. Smith</u>				22d. ADDRESS <u>Greater Balto. Med. Center</u>			
23a B. URIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md. 21212</u>				25a REC'D BY REGISTRAR DATE <u>MAY 23 1967</u>		25b REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

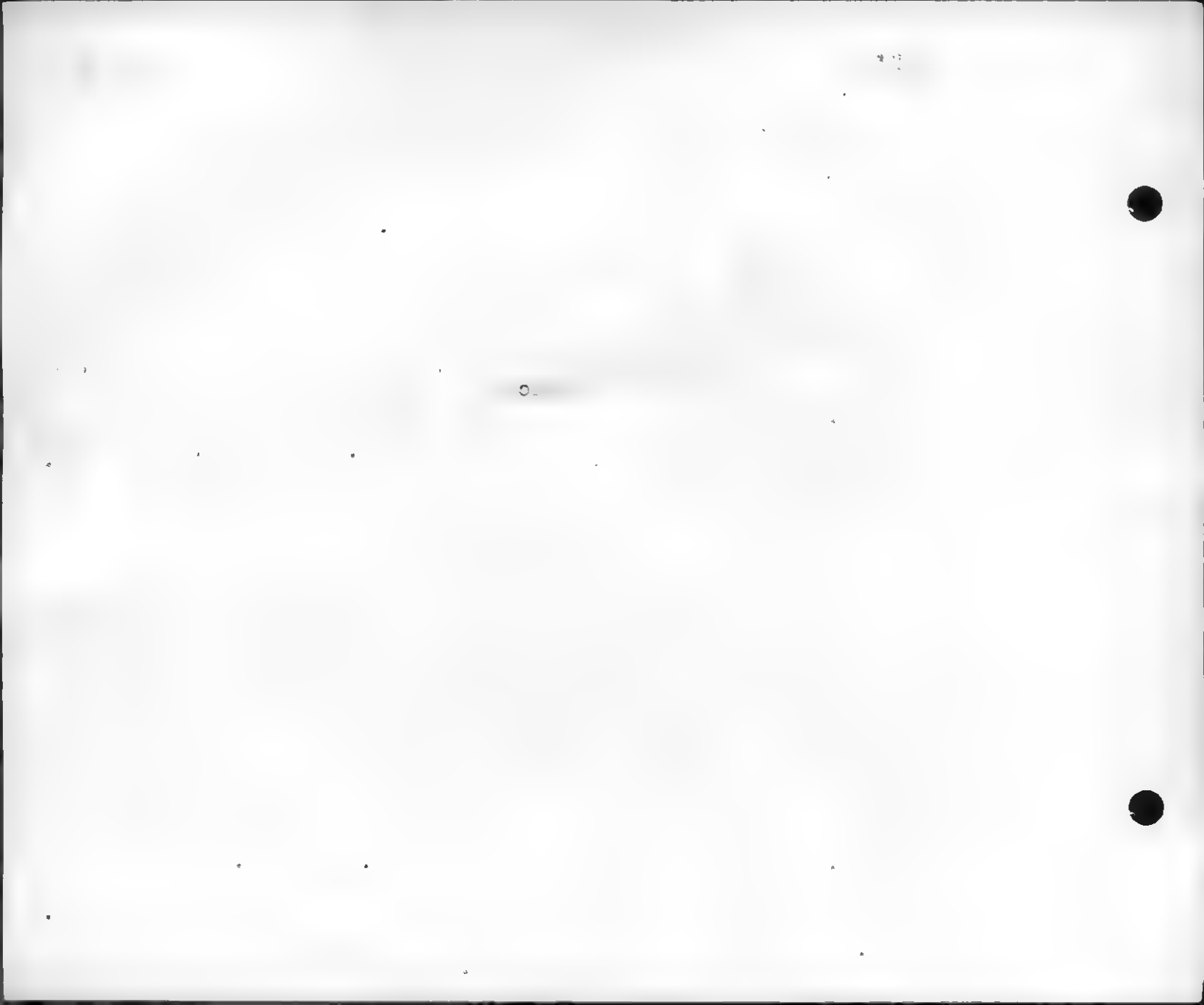
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06225

CERTIFICATE OF DEATH

06216

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b 3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor Nursing Home			e. STREET ADDRESS 306 E. 32nd Street		
3 NAME OF DECEASED (Type or print) First Ella Middle Cobb Last Bush			4. DATE OF DEATH Month May Day 24 Year 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/18/83	9. AGE (In years last birthday) 83 yrs	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Johns Hopkins Hosp. Maryland		11. BIRTHPLACE (County & State, or foreign country) U.S.A.	
13. FATHER'S NAME Albert H. Bush			MOTHER'S MAIDEN NAME Margaret Elizabeth Hughes		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 220-30-2972		17. INFORMANT Address Frederick J. Singley, Jr. Bank Bldg.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____ (b) _____ DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item B)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (1) (this hospital) attended the deceased from _____, 19____, to _____, 19____; that (1) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from causes and on the date stated above.					
22a. SIGNATURE Dr. Franklin Leslie			22b. DATE SIGNED 5-25-67		22c. PHYSICIAN'S NAME (Type) Dr. Franklin Leslie
22d. ADDRESS 302 E. 33rd St.					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 5/26/67	23c. NAME OF CEMETERY OR CREMATORY Greenmount	23d. LOCATION (City or town)	(County)	(State) Md.
24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co.			25. REGISTRAR'S SIGNATURE Charles Jones		
ADDRESS 4905 York Rd.			DATE MAY 26 1967		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06226

CERTIFICATE OF DEATH

06217

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PERRY HALL</u>			c. LENGTH OF STAY IN 1b <u>34 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PERRY HALL</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9714 BELAIR ROAD</u>				d. STREET ADDRESS <u>9714 BELAIR ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HENRY Anthony BUTT</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 9, 1897</u>		9. AGE (In years last birthday) <u>69 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MOTEL</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY S. BUTT</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH PRISKEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> <u>NONE</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>WILBERT GRIES 1735 W. PRATT ST.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of right lung</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>April 6, 1967</u> , to <u>May 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 7, 1967</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Frank N. Goode</u>				22b. DATE SIGNED <u> </u>		22c. PHYSICIAN'S NAME (Type) <u>FRANK N. GOODE, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-11-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MD.</u>	
24. FUNERAL DIRECTOR <u>Geo. L. Schwab Funeral Home</u>				25a. REC'D BY REGISTRAR <u>MAY 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

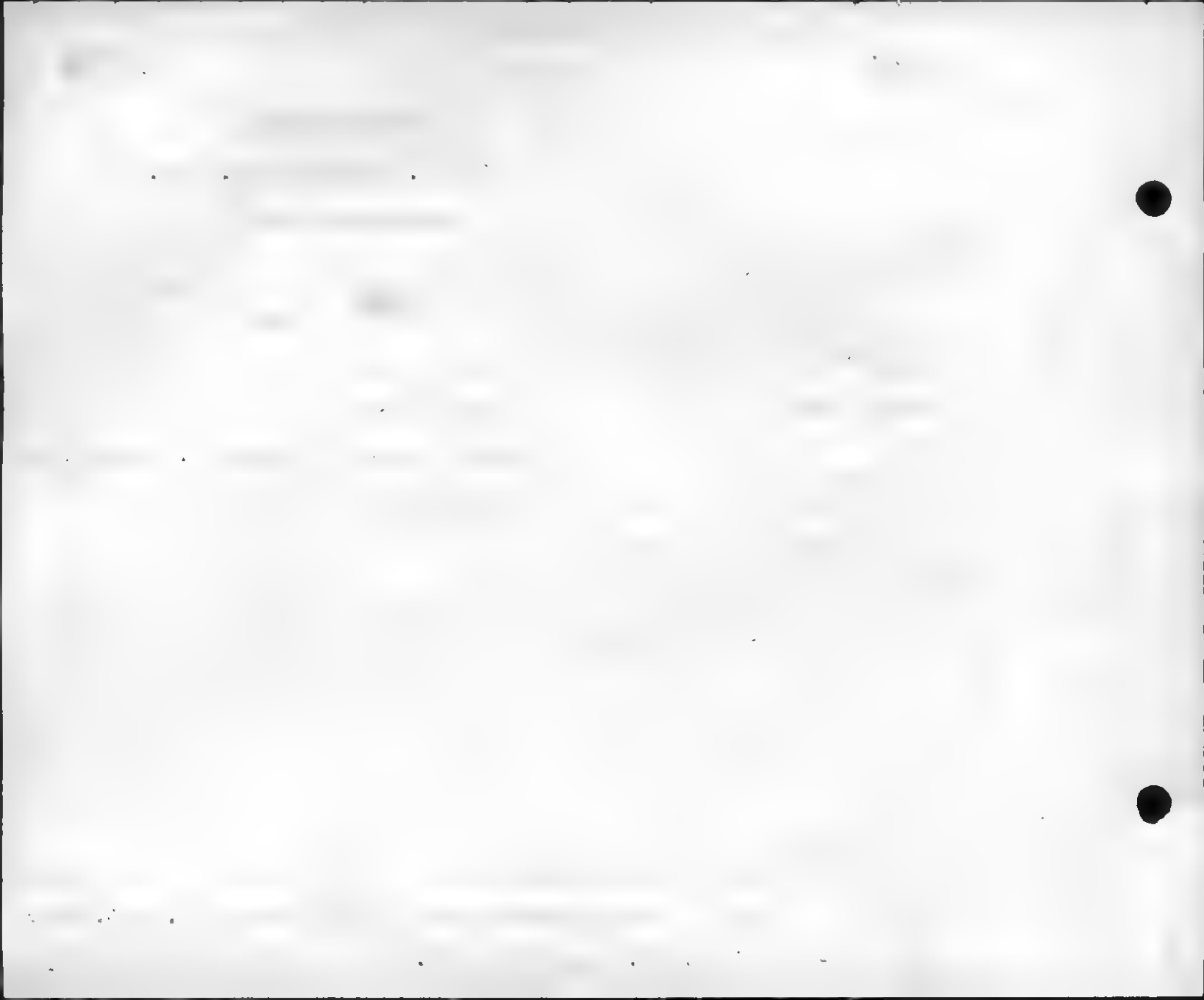
06227

CERTIFICATE OF DEATH

06218

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>md</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN lb <u>1 day</u>		3312 W. Strathmore Ave. Balt. 21215	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>3312 W. Strathmore Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Louise C. Byers</u>		4 DATE OF DEATH Month Day Year <u>5 8 1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-14-1929</u>
		9 AGE (In years last birthday) <u>37</u> yrs	10. IF UNDER 1 YEAR Months Days
		11. IF UNDER 24 HRS Hours Min	12. CITIZEN OF WHAT COUNTRY? <u>yes</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY	
13 FATHER'S NAME <u>Charles Zentz</u>		14 MOTHER'S MAIDEN NAME <u>Agnes Bankard</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO	
		17 INFORMANT Address <u>Loring Byers-8728 Liberty Rd. Randallstown</u>	
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>ASHD</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Abdomen</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-7</u> , 19 <u>67</u> , to <u>5-8</u> , 19 <u>67</u> that (I) (we) lost saw the deceased alive on <u>5-8</u> , 19 <u>67</u> , and that death occurred at <u>5-8</u> , 19 <u>67</u> , M, from causes on and on the date stated above.			
22a SIGNATURE <u>Rupert Manankil</u>		22b DATE SIGNED <u>5-8-67</u>	
22c PHYSICIAN'S NAME (Type) <u>RUPERTO MANANKIL</u>		22d ADDRESS <u>BOB H</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>3/15/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Office- 505 Cathedral St. Balt. 21201</u>
24. FUNERAL DIRECTOR		25a RECD BY REGISTRAR <u>Charles Judge</u>	
<u>Loring Byers-8728 Liberty Rd. Randallstown, Md</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MAY 15 1967



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

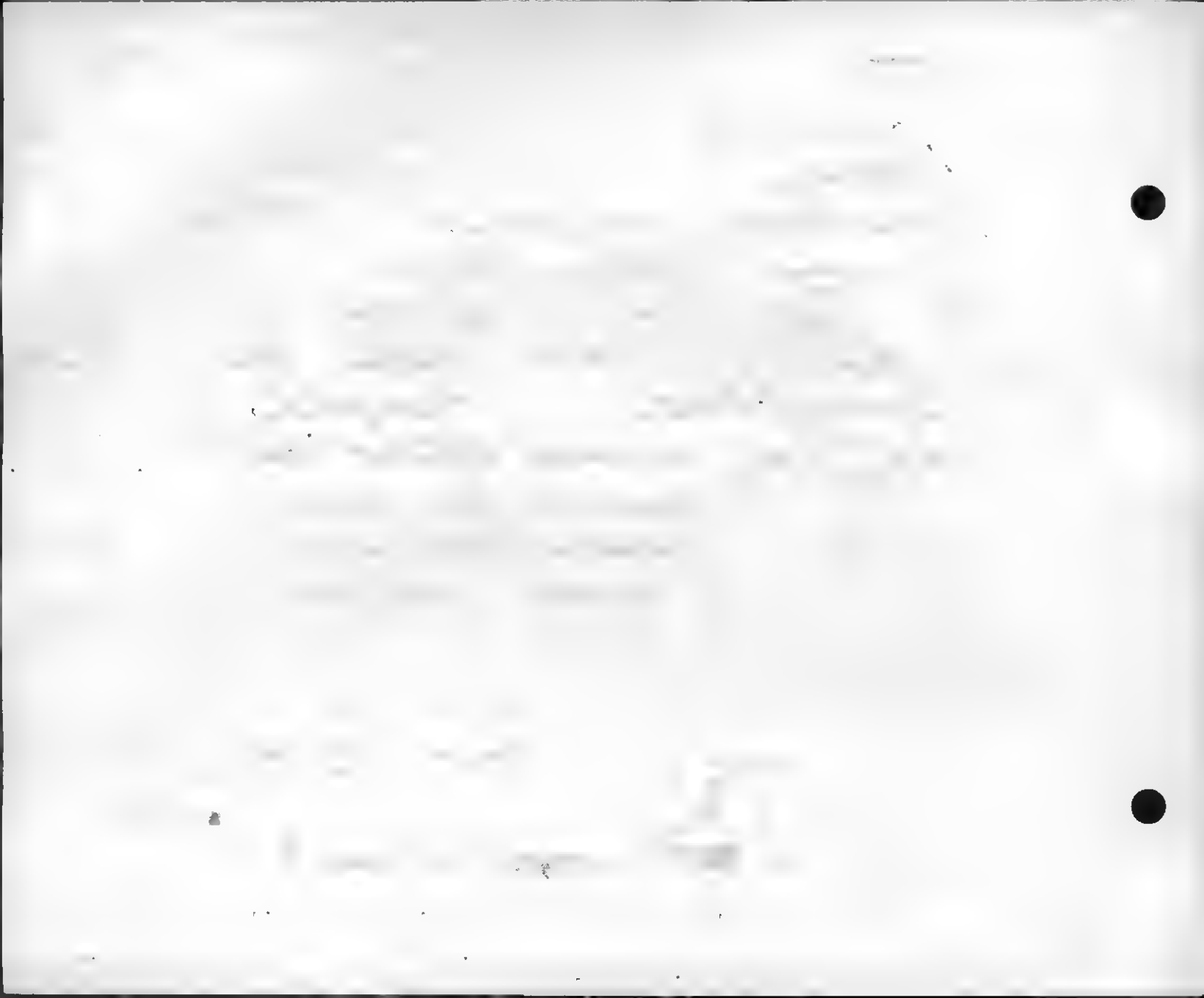
06228

06219

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN TB <u>6 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>514 E. 39th St</u>		d. STREET ADDRESS <u>514 E. 39th St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Unie Catherine Byrd</u>		4. DATE OF DEATH <u>5 8 19 67</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>Can</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10/9/84</u>
9 AGE (In years last birthday) <u>82</u> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NA</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Balto., Md.</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13 FATHER'S NAME <u>George C. Parks</u>		14 MOTHER'S MAIDEN NAME <u>Marjorie Ella</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NA</u> (If yes give war or dates of service) <u>NA</u>		16 SOCIAL SECURITY NO <u>218-542467</u>	
17. INFORMANT <u>Patient Chart</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Congestive Heart Failure +</u> DUE TO (c) <u>Cardiac Arrhythmia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>46 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 2</u> , 19 <u>67</u> , to <u>May 8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 8</u> , 19 <u>67</u> , and that death occurred at <u>11:15 AM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Ludmila M. Okeyza</u> MD		22b. DATE SIGNED <u>5/8/67</u>	
22c PHYSICIAN'S NAME (Type) <u>Dr. L. [redacted] M. [redacted]</u>		22d ADDRESS <u>GBMC, Charles St. Md.</u>	
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>May 11, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>	23d LOCATION (City or Town) (County) (State) <u>Balto., Md.</u>
24 FUNERAL DIRECTOR ADDRESS <u>Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md. 21212</u>		25a REC'D BY REGISTRAR <u>MAY 9 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1 MD TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

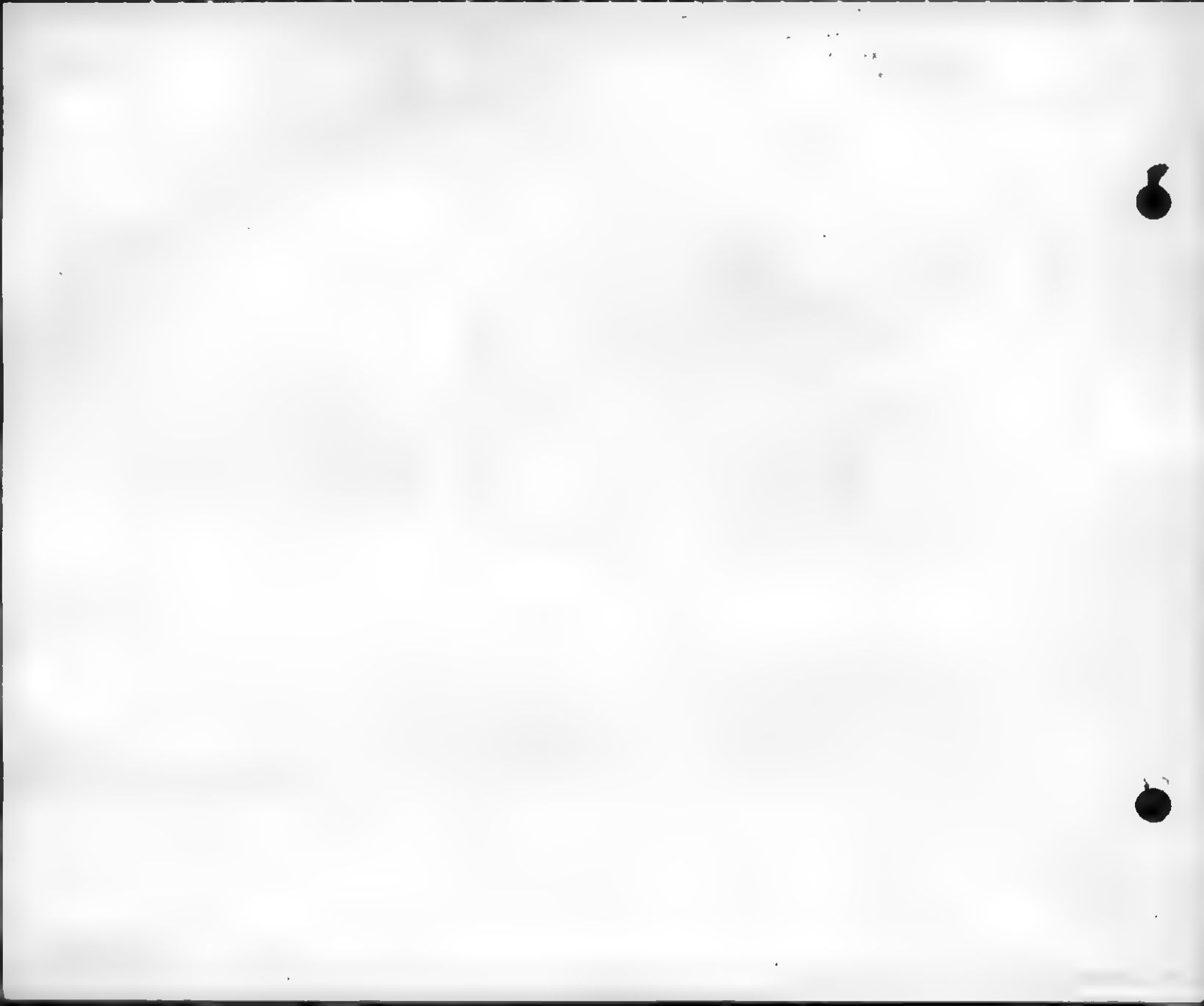
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06223

CERTIFICATE OF DEATH

06220

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c LENGTH OF STAY in 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>908 C ASHBRIDGE DR</u>				d. STREET ADDRESS <u>908 C ASHBRIDGE DR</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>THELMA BYRNE</u> First Middle Last				4 DATE OF DEATH <u>MAY 8 1967</u> Month Day Year			
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>JUNE 8 1909</u>	9 AGE (In years last birthday) <u>57</u> Yrs	F UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>VA.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEO A. CLANKENSHIP</u>				14. MOTHER'S MAIDEN NAME <u>JOSEPHINE LOTH</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO		17 INFORMANT <u>PAUL BYRNE</u>		Address <u>ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>anoxia from</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 pulmonary infection</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-1</u> , 1967, to <u>5-8</u> , 1967 that (I) (we) last saw the deceased alive on <u>5-8</u> 1967, and that death occurred at <u>3A</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>[Signature]</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>MAY 11, 1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>HOLLY HILLS</u>		23d LOCATION (City or Town) (County) (State) <u>BALCO. MD</u>	
24. FUNERAL DIRECTOR <u>JG CONNELLY SONS</u>				25a REC'D BY REGISTRAR DATE <u>MAY 12 1967</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06230

CERTIFICATE OF DEATH

00221

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2221 Baltimore 21216</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				d. STREET ADDRESS <u>2221 ELSINORE AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>A. Brown Caldwell</u>				4. DATE OF DEATH Month <u>5</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Can.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-2-90</u>		9. AGE (In years last birthday) <u>76</u> yrs	10. UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Williamsport, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John E. Caldwell</u>				14. MOTHER'S MAIDEN NAME <u>Anna Brown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>212-14-3168</u>		17. INFORMANT <u>MARGARET WYSONG - 1902 Princeton Place Rockville, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Resp. Failure</u> DUE TO (b) <u>Sarcoma of bladder</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <u>May 14, 1967</u> to <u>May 14, 1967</u> , that (we) last saw the deceased alive on <u>12-05 AM 19</u> , and that death occurred on <u>12-05 AM</u> from causes and on the date stated above							
22a. SIGNATURE <u>Dennis Chan</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>May 14 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>DENIS CHAN</u>				22d. ADDRESS <u>G B M C</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-18-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md</u>	
24. FUNERAL DIRECTOR <u>ELLSWORTH ARMACOST - 4600 Liberty Heights Ave</u>				25a. RECEIVED BY REGISTRAR <u>17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

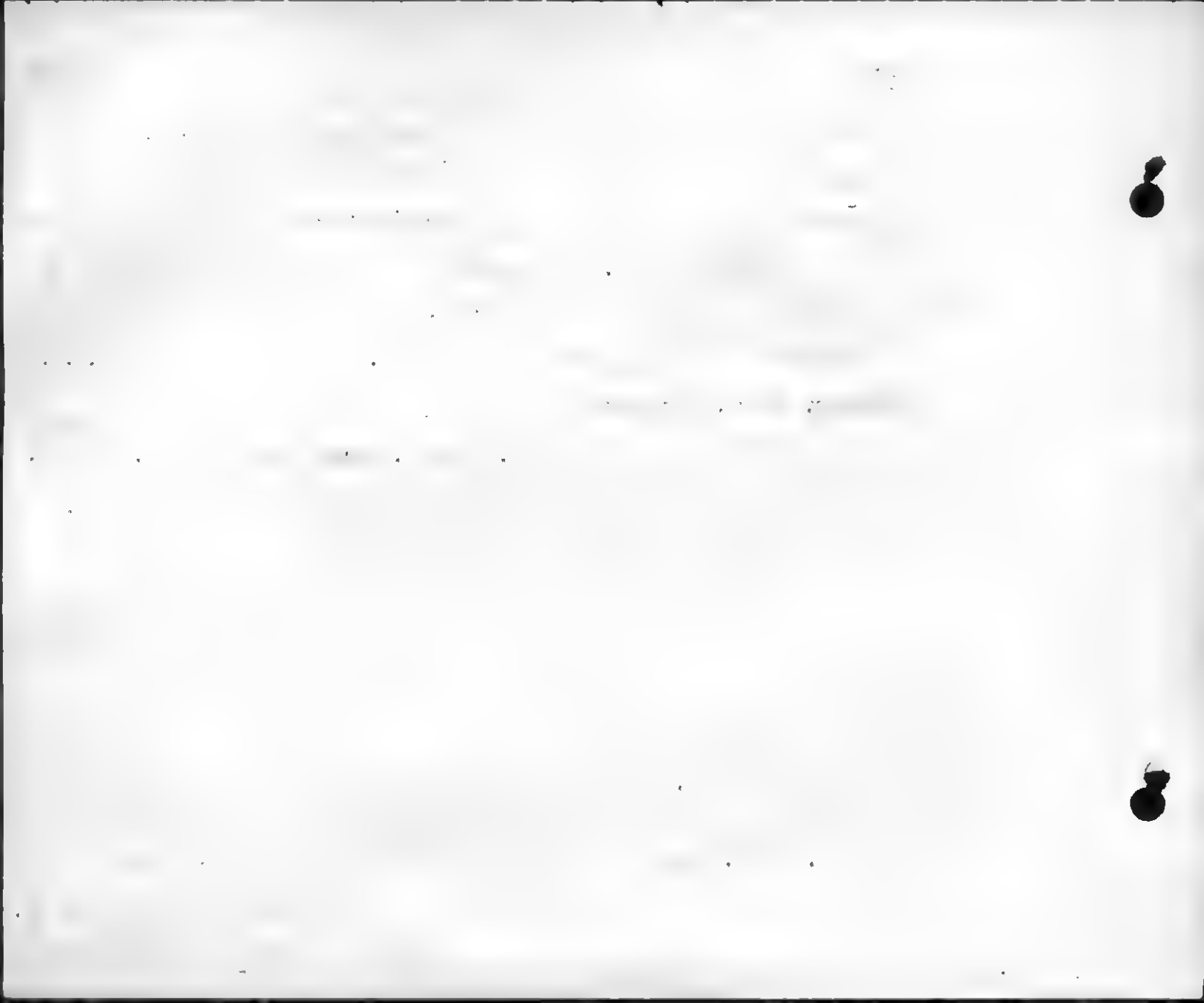
36231

CERTIFICATE OF DEATH

36222

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7416 Monita Road				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville d. STREET ADDRESS 7416 Monita Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Bertha M. Carey				4. DATE OF DEATH Month Day Year May 7 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 7, 1889		9. AGE (In years birth day) 78 If UNDER 1 YEAR: Months Days Hours Min. If UNDER 24 HRS:	
10a. USUAL OCCUPATION (Give kind of work done during most of working life) Housewife			10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State or foreign country) Balto. Md			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harrold Welle, Alexander					14. MOTHER'S MAIDEN NAME (unknown) Strauss				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO 217-36-3761T		17. INFORMANT Address Pikesville Md. Mr. Jerry P. Carey 7416 Monita Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Kidney, left DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 6 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (Physician) attended the deceased from May 19 1958 to May 19 1967, that (I) (two) saw the deceased alive on May 1 19 67, and that death occurred at 4:45 PM, from causes and on the date stated above.									
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) Dr. Lee J. Gaver						22b. DATE SIGNED 5/8/67		22d. ADDRESS 1 Mallow Hill Rd. Balto 29, Md	
23a. BURIAL, CREMATION, REINTERMENT (Type) Burial		23b. DATE THEREOF 5/10/67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park			23d. LOCATION (City or Town) (County) (State) 3801 Frederick Rd Balto Md.		
24. FUNERAL DIRECTOR ADDRESS Spring Byers 8728 Liberty Rd						25a. REC'D BY REGISTRAR MAY 11 1967		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

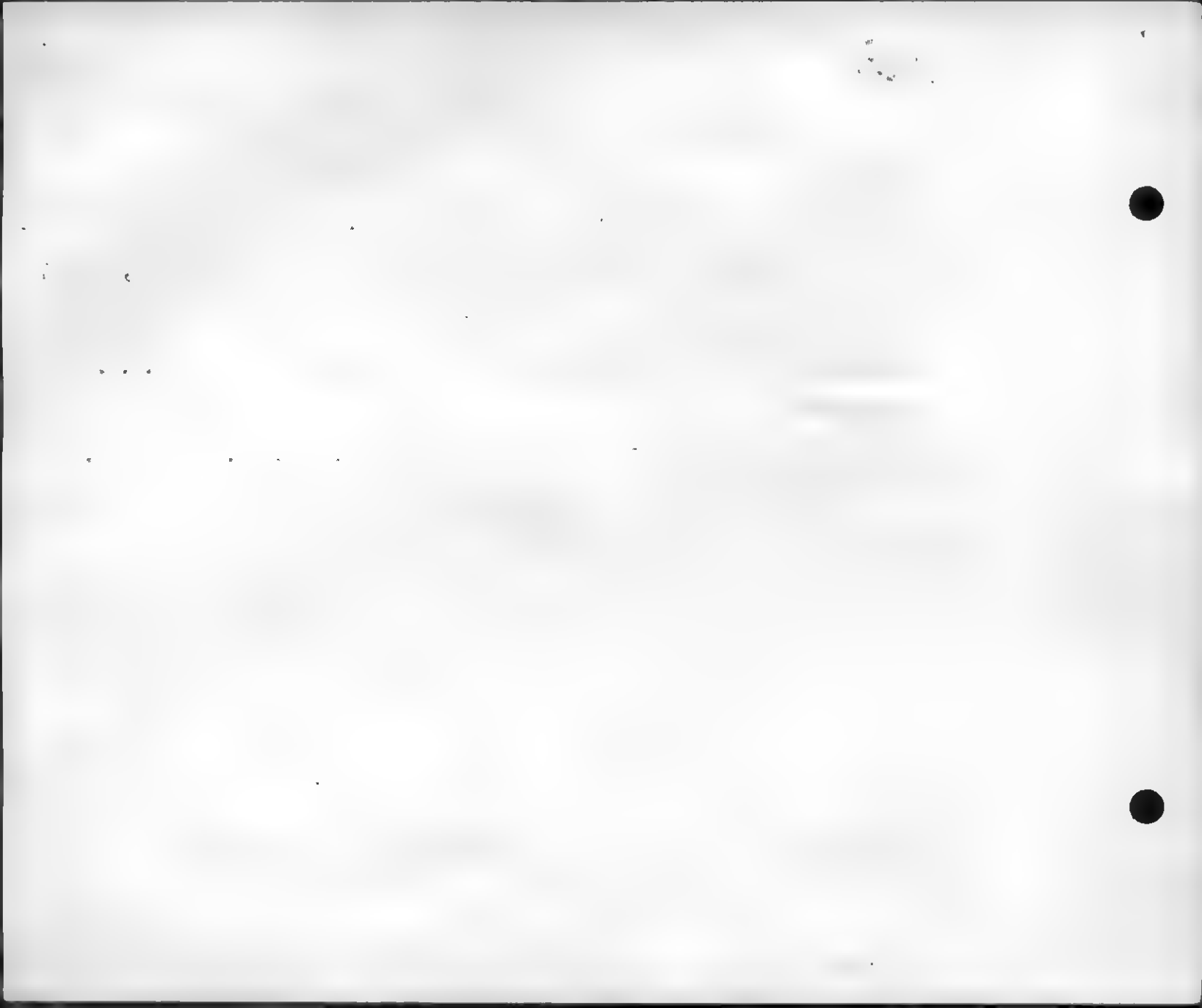
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06232

CERTIFICATE OF DEATH

06223

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a STATE MARYLAND b COUNTY ---	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c LENGTH OF STAY IN TB 16 DAYS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e STREET ADDRESS 11 BRISTOL AVENUE	
3 NAME OF DECEASED (Type or print) First STANLEY Middle NMI Last CARSON		4 DATE OF DEATH Month MAY Day 6 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 4/18/09
9 AGE (In years last birthday) 58 yrs		10 UNDER 1 YEAR Months --- Days ---	11 UNDER 24 HRS Hours --- Min ---
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		10b KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
11 BIRTHPLACE (County & State or foreign country) CANADA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT CARSON		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES KOREAN		16 SOCIAL SECURITY NO 212 12 22 92	
17 INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE 570-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) LIVER FAILURE DUE TO (c) PARALYTIC ILEUS		INTERVAL BETWEEN ONSET AND DEATH 48 Hours 1 Week 1 Week	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. ---		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from April 20 , 19 67 , to May 6 , 19 67 , that (X) (we) last saw the deceased alive on May 6 , 19 67 , and that death occurred at 8 P.M. from causes and on the date stated above.			
22a SIGNATURE <i>Milton Ginsberg</i>		22b DATE SIGNED 5/8/67	
22c PHYSICIAN'S NAME (Type) MILTON GINSBERG, M.D.		22d ADDRESS VA Hospital, Fort Howard, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF MAY 10, 1967	23c NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City or Town) (County) (State) Baltimore Maryland
24 FUNERAL DIRECTOR George J. Gonce Funeral Home		25a REC'D BY REGISTRAR 4001 Gov. Ritchie Highway Balto	
25b DATE MAY 11 1967		25c SIGNATURE <i>John Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

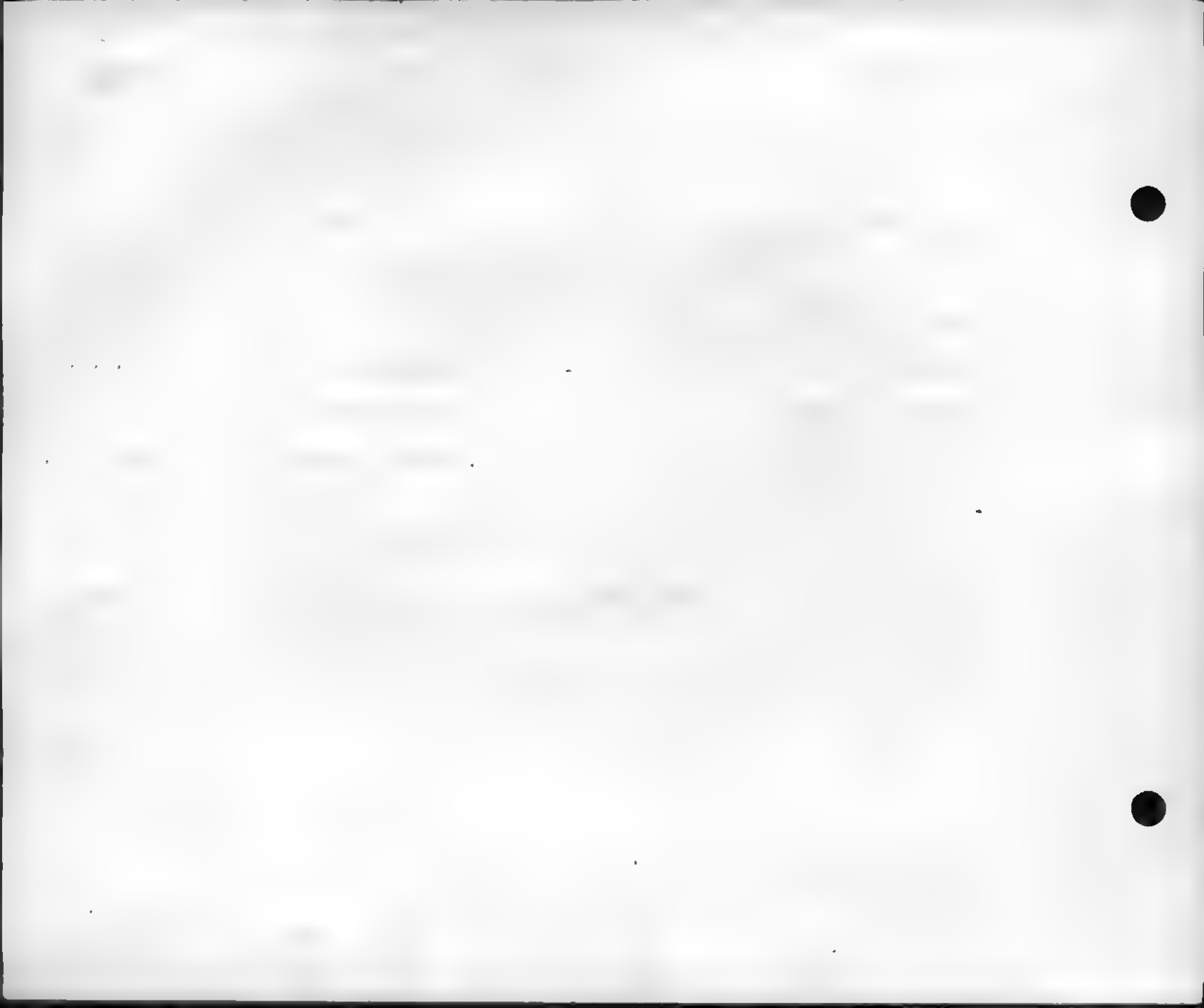
06233

06224

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN b. 14 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 3200 OLD NORTH POINT ROAD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last ANTHONY STEVEN CATRAMADOS		4 DATE OF DEATH Month Day Year MAY 1 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/3/29
9. AGE (In years last birthday) 38 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		10b. KIND OF BUSINESS OR INDUSTRY BARBER SHOP	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STRATIS CATRAMADOS		14. MOTHER'S MAIDEN NAME EUGENIE CALAVETINOS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 217 22 91 89	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE Condit.ans, if any, which gave rise to immediate cause (a), stating the underlying cause (c) BRONCHOGENIC CYST		INTERVA. BETWEEN ONSET AND DEATH MINUTES UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 4/17/67 , 19 to 5/1/67 , 19, that (if we) last saw the deceased alive on 5/1/67 , 19, and that death occurred at 2:45P M, from causes and on the date stated above.			
22a. SIGNATURE <i>Peter J. Juvan</i>		22b. DATE SIGNED 5/2/67	
22c. PHYSICIAN'S NAME (Type) PETER J. JUWAN, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/4/67	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NAT. CEMETERY		23d. LOCAT ON (City or town) (County) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR Chris S. Frause		25. RECEIVED BY REGISTRAR MAY 4 1967	
26. ADDRESS 1216 S. CHARLES ST. BALTIMORE, MD.		27. REGISTRAR'S SIGNATURE <i>Charles J. Juvan</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

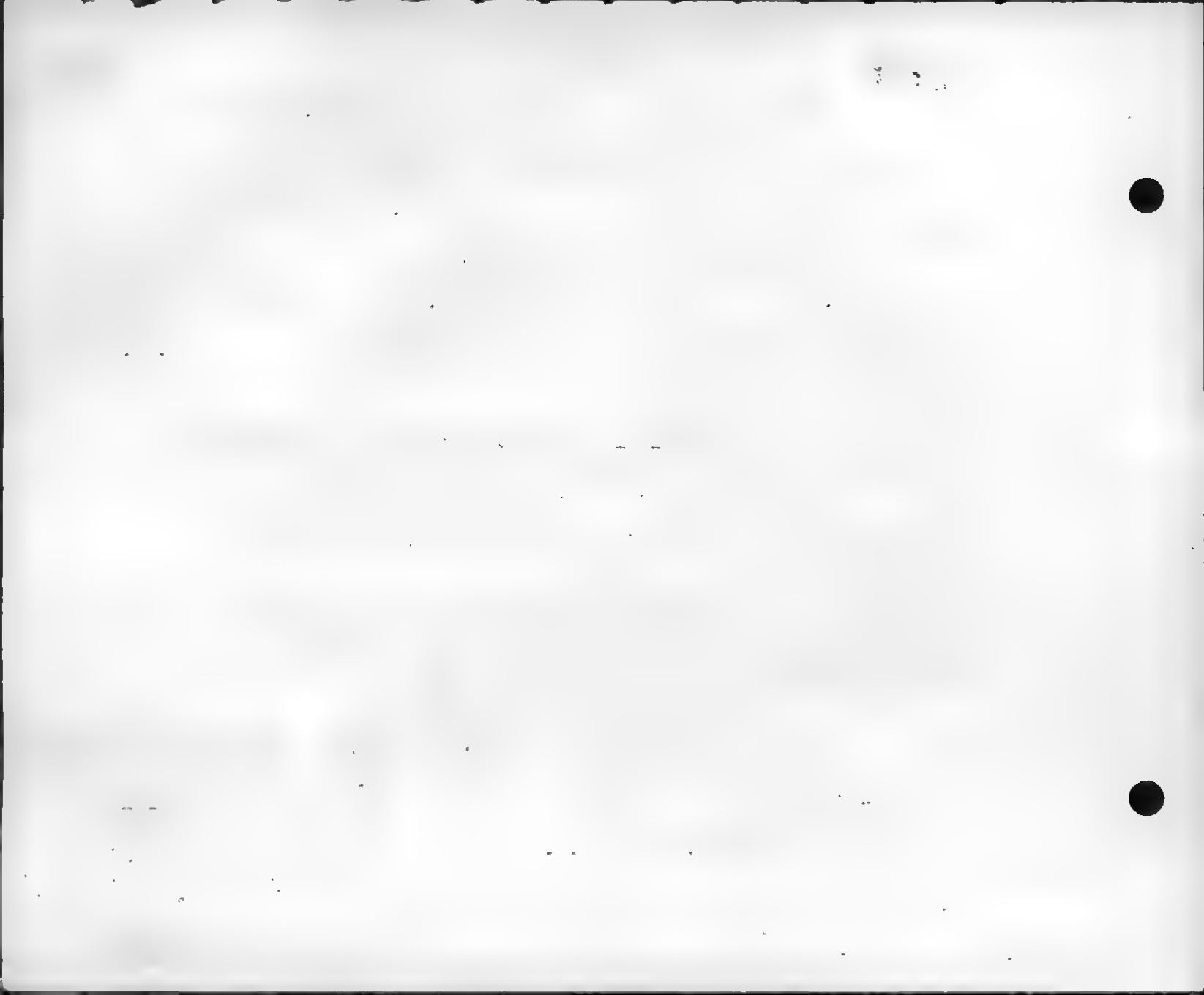


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1D 22yr4mth21dys		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Margaret		First		Middle		Last		4. DATE OF DEATH Month May Day 9 Year 19 67	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1883		9. AGE (in years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 219-54-3068J1		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Duodenal ulcer with bleeding								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from Dec. 18 1964 to May 9 1967 , that no (we) last saw the deceased alive on May 9 1967 , and that death occurred at 12:05 M, from the causes and on the date stated above.									
22a. SIGNATURE <i>Anthony G. Young</i>				a. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 5-9-67	
22c. PHYSICIAN'S NAME (Type) Anthony G. Young, M.D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF May 11 1967		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town or county) (State) Old Friends Burial Bldg. Baltimore			
24. FUNERAL DIRECTOR Krause Funeral Home 1216 S Charles St				25a. REC'D BY REGISTRAR MAY 15 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

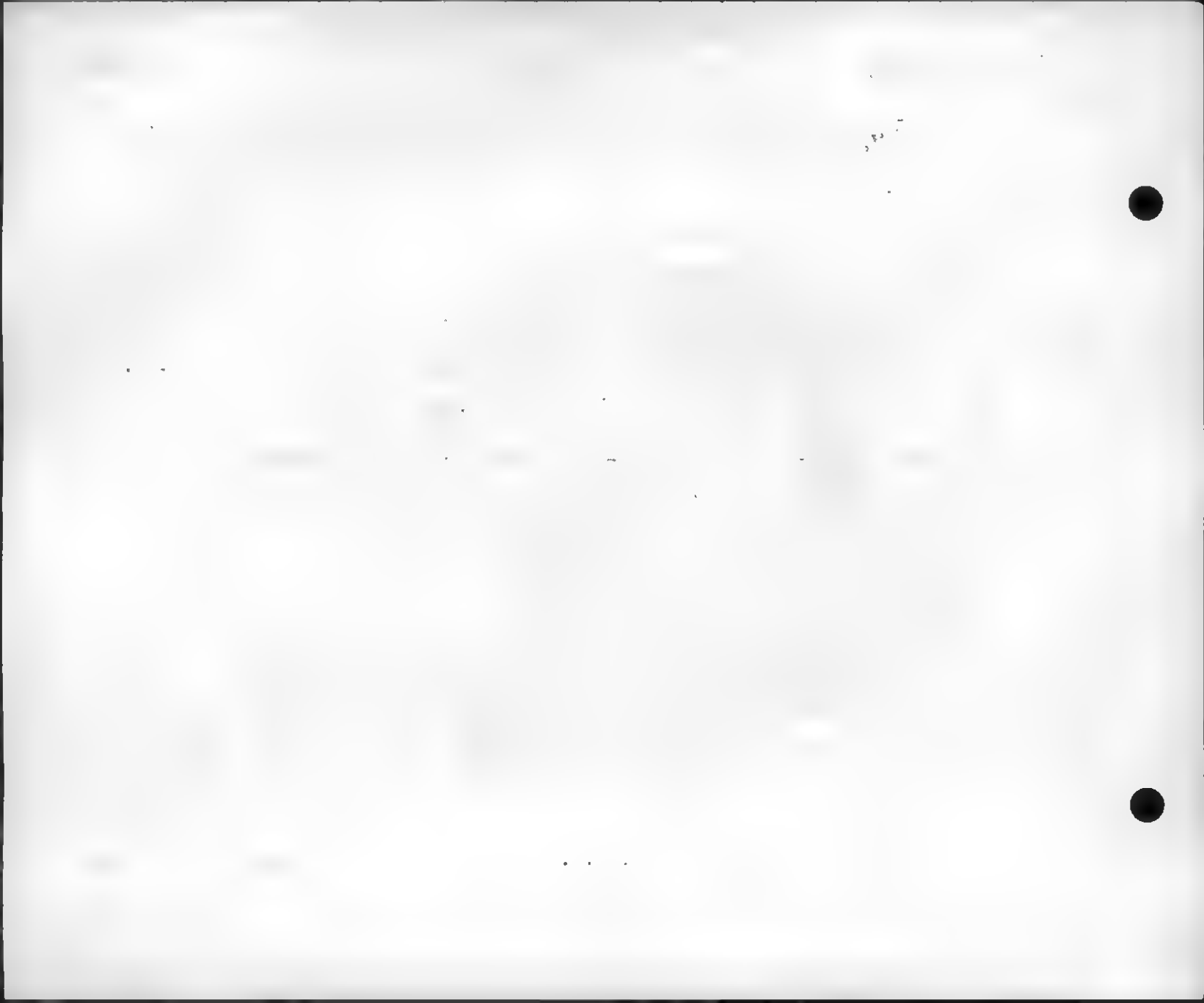
06235

CERTIFICATE OF DEATH

06226

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 3mth20dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 216 East Cross Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gordon Middle Oscar Last Cole				4. DATE OF DEATH Month May Day 14 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1902		9. AGE (In years last birthday) 64 yrs	10. IF UNDER 1 YEAR Months 6 Days 14 Hours 19 Min 67	11. IF UNDER 24 HRS Months 6 Days 14 Hours 19 Min 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) truck driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Oscar Cole				14. MOTHER'S MAIDEN NAME Jenny Scott			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Army 1918-19		16. SOCIAL SECURITY NO. 214-01-8514		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of lungs X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 24 , 19 67 , to May 14 , 19 67 , that (I) (we) last saw the deceased alive on May 14 , 19 67 , and that death occurred at 7:45 P.M., from causes and on the date stated above.							
22a. SIGNATURE Stella Wachslor		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-15-67			
22c. PHYSICIAN'S NAME (Type) Stella Wachslor, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/18/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc., 1501 East Fort Avenue		25a. REC'D BY REGISTRAR DATE MAY 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06236

CERTIFICATE OF DEATH

06227

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <i>Md.</i> b COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b <i>Towson</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>601 Sussex Road</i>		d. STREET ADDRESS <i>601 Sussex Road</i>	
3 NAME OF DECEASED (Type or print) First <i>Isabelle</i> Middle <i>V.</i> Last <i>Conway</i>		4 DATE OF DEATH Month <i>May</i> Day <i>28</i> Year <i>19 67</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-14-1884</i>
9. AGE (in years last birthday) <i>82</i>		10. FUNDING YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thompson</i>		14. MOTHER'S MAIDEN NAME <i>not known</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO <i>214323111A</i>	
17. INFORMANT <i>Thomas O. Carroll</i>		Address <i>same</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>20 years</i>
19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour am p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <i>May 17, 1967</i> to <i>May 29, 1967</i> , that (I) (we) last saw the deceased alive on <i>May 17, 1967</i> , and that death occurred at <i>5:30 AM</i> , from causes and on the date stated above			
22a. SIGNATURE <i>Thomas J. Brennan</i> M.D.		22b. DATE SIGNED <i>29 May 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>Thomas J. Brennan, M.D.</i>		22d. ADDRESS <i>5217 Harford Road Baltimore 21214</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>6-1-67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St. Peter & Paul Cem</i>		23d. LOCATION (City or Town) (County) (State) <i>Cumberland, Md.</i>	
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc Baltimore, Md.</i>		25a. REC'D BY REGISTRAR <i>MAY 29 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>g Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
 Item 3 Film G 388 5/10

05228

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Summit Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u> Md. </u> b. COUNTY <u> </u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> d. STREET ADDRESS <u>Rt 2 - Box 266</u>	
3. NAME OF DECEASED (Type or print) <u>Gloyd</u> <u>T.</u> <u>Cook</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>6-14-40</u>	
9. AGE (In years last birthday) <u>26</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen Elec</u>		11. BIRTHPLACE (Country & State, or foreign country) <u> Md. </u>	
13. FATHER'S NAME <u>Leodore</u>		14. MOTHER'S MAIDEN NAME <u>Frances Boyle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Family - Same</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Infection</u> DUE TO (b) <u>Lung Tumor (Metastasis)</u> (a), stating the underlying cause last. (c) <u>Bladder malignancy</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>8 min</u> <u>1 1/2 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/1/67</u> <u>1967</u> <u>to</u> <u>5/5/67</u> <u>1967</u> <u>that (I) (we) last saw the deceased alive on</u> <u>5/1/67</u> <u>1967</u> <u>and that death occurred at</u> <u>12:30 M.</u> <u>from the causes and on the date stated above</u>			
22a. SIGNATURE <u>Wm Louis J. Ratliff</u> M.D.		22b. DATE SIGNED <u>5/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CLIFFE RATLIFF, JR.</u>		22d. ADDRESS <u>4605 EDMONDSON AVE #22</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		23b. DATE THEREOF <u>5/8/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green Grove</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Louis J. Ratliff</u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>MAY 8 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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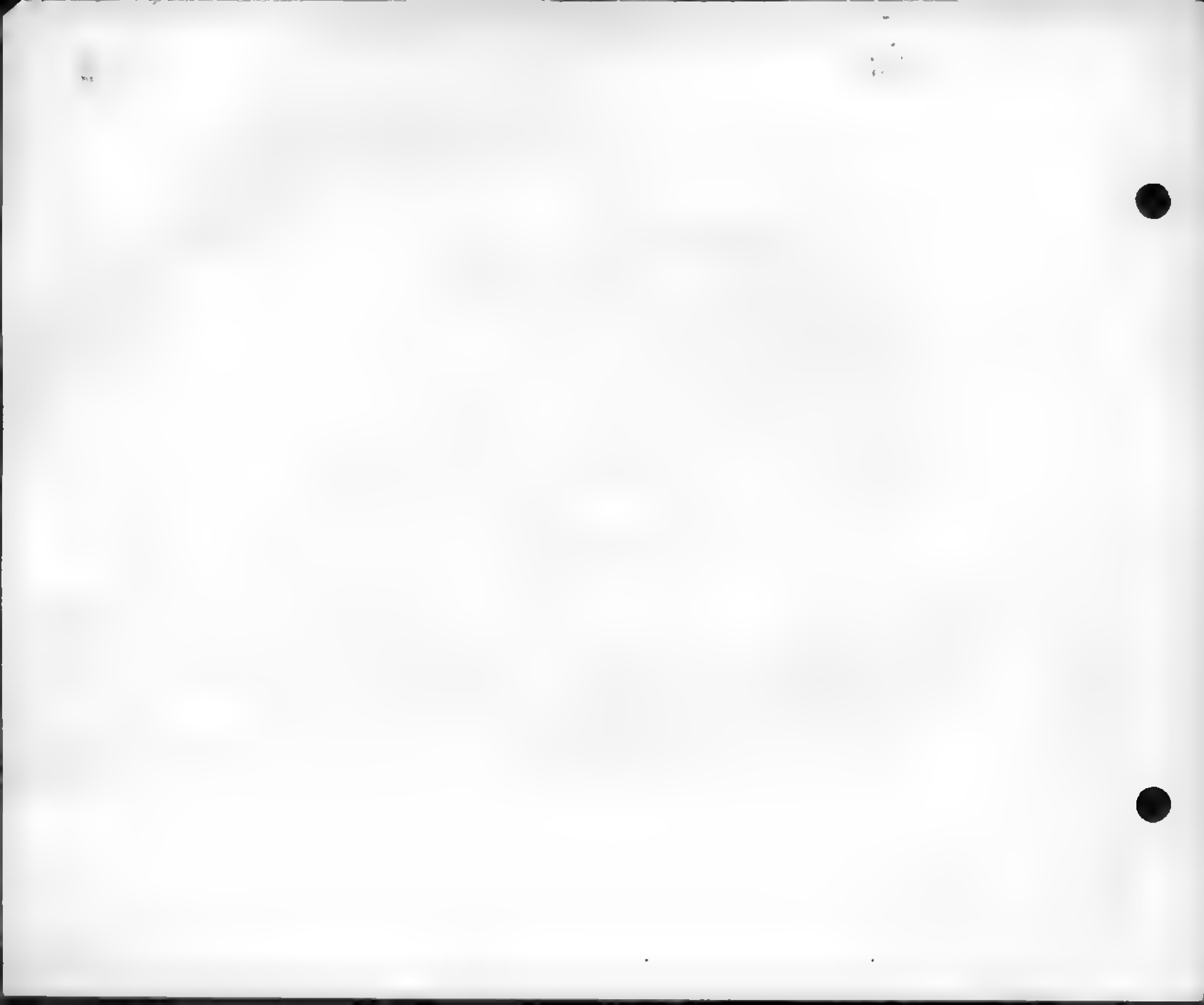
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36238

CERTIFICATE OF DEATH

00029

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>---</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabinville</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>321 Oaklee Village - Z-29</u>	
3 NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Ellen</u> Last <u>Coppinger</u>		4 DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>19 67</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-09-02</u>
9a. AGE (In years last birthday) <u>64</u> yrs		9b. IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min <u>---</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11 BIRTHPLACE (County & State or foreign country) <u>IRELAND</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13 FATHER'S NAME <u>PATRICK KERRIGAN Kerrigan</u>		14 MOTHER'S MAIDEN NAME <u>MARGARET CARTY</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO <u>---</u>	
17 INFORMANT <u>WILLIAM COPPINGER</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>---</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>	20f. (City or town) (County) (State) <u>---</u>
21. I certify that (I) (this hospital) attended the deceased from <u>4-28, 1967</u> to <u>5-1, 1967</u> that (I) (we) last saw the deceased alive on <u>5-1, 1967</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Rolando Vieta</u>		22b. DATE SIGNED <u>5-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROLANDO VIETA</u>		22d. ADDRESS <u>Spring Grove State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5-5-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24 FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Avenue 21229</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 3 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 11-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

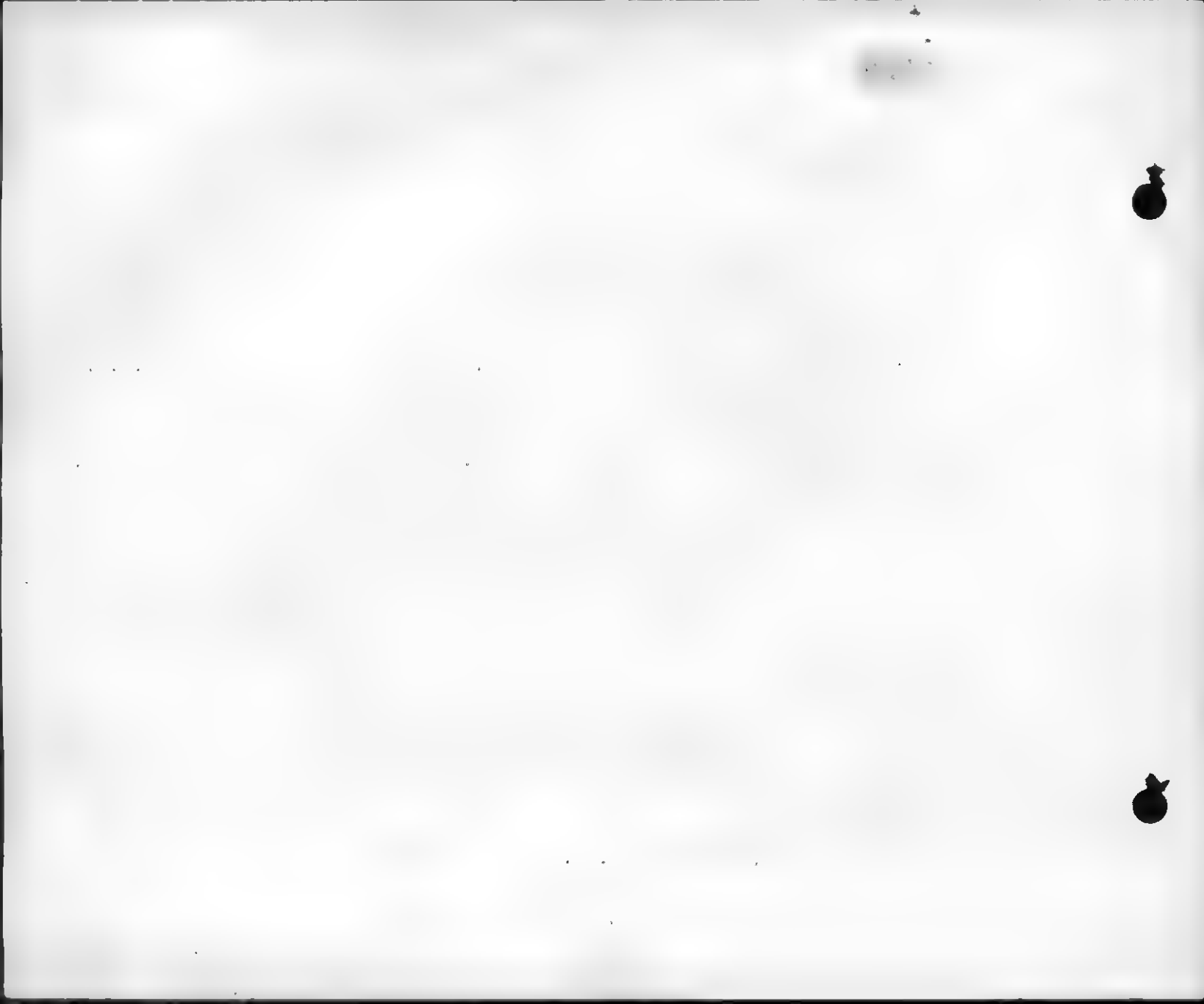
36233

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

36233

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c LENGTH OF STAY IN TB 1 Hour	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e STREET ADDRESS 1616 Dogwood Hill Rd.	
3 NAME OF DECEASED (Type or print) Sarah Long Cornthwaite		4 DATE OF DEATH May 7, 1967	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/14/24
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guidance counselor		10b KIND OF BUSINESS OR INDUSTRY School	9 AGE (in years last birthday) 42 yrs
11 BIRTHPLACE (State or foreign country) Ocala, Fla.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME John Long		14 MOTHER'S MAIDEN NAME Evlyn Moon	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 262-26-3232	
17 INFORMANT Mr. David L. Cornthwaite		Address 1616 Dogwood Hill	
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)). PART I DEATH WAS CAUSED BY 4/5/67 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o m p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 5/7/67	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 5/10/67	23c NAME OF CEMETERY OR CREMATORY Friends Burial Grounds Cem.	23d LOCATION (City or Town) (County) (State) Baltimore, Maryland
24 FUNERAL DIRECTOR Wm. Cook-Brooks		25a REC'D BY REGISTRAR May 10 1967	
ADDRESS Towson 1050 York Rd. 21204		25b REGISTRAR'S SIGNATURE O'Donnell Judge	





FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil. 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Other along with form PM3. Page 5 may be retained for your files.

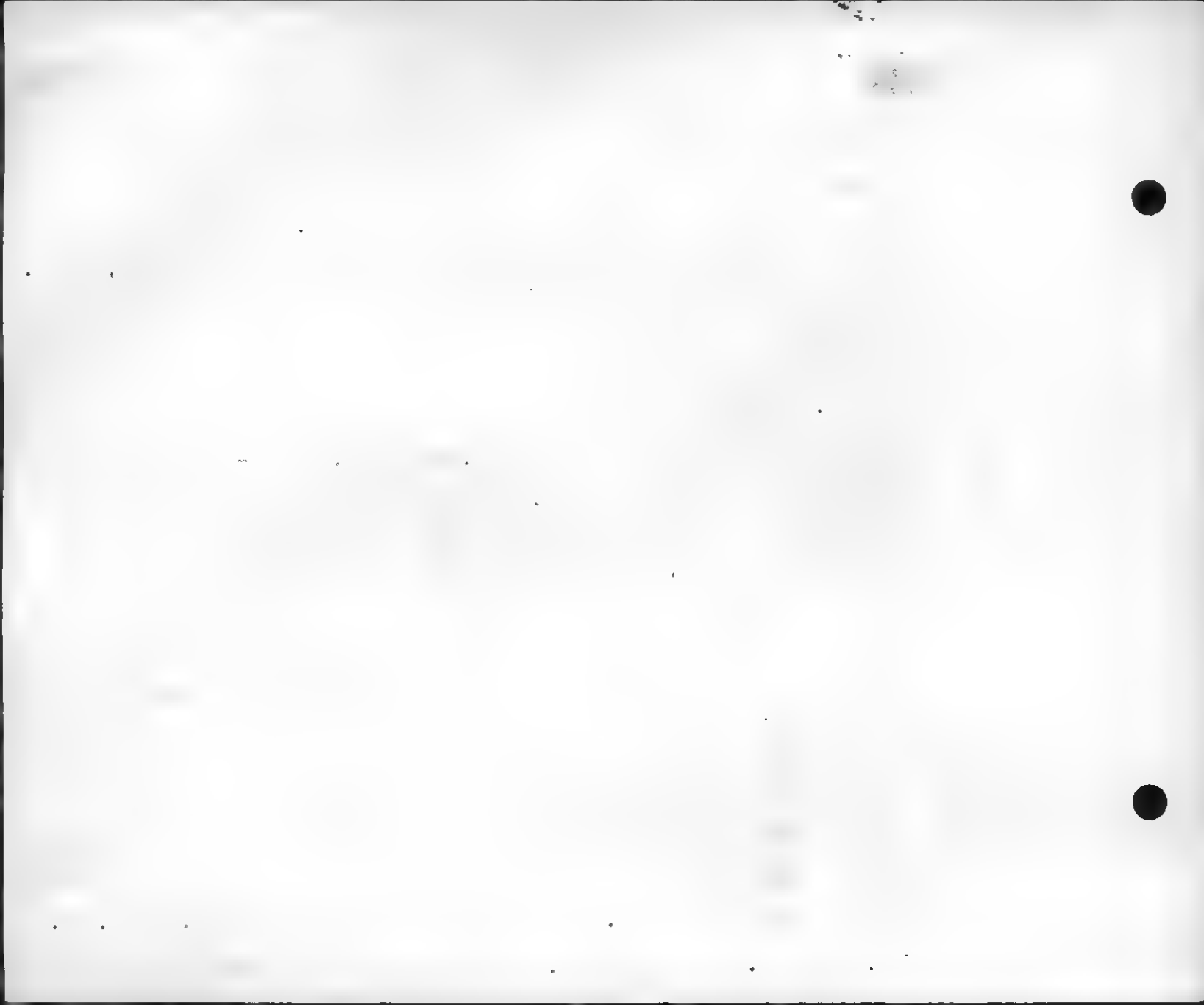
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Res. den. before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sweetair		c. LENGTH OF STAY IN lb Baldwin	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Baldwin Mill Rd., Box 181	
3 NAME OF DECEASED (Type or print) First REGINA Middle ANN Last DALTON		4 DATE OF DEATH Month MAY Day 16, Year 19 67.	
5 SEX Female	6 CO. OR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2/27/1945
9. AGE (in years lost birthday) 22 yrs		F UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William M. Dalton		14 MOTHER'S MAIDEN NAME Gertrude R. Riley	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT Mr. William M. Dalton- Same		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Crushing Injury to Skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Multiple Body Fractures (c) RT Femur Fracture		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driving Auto that Ran off Road & Struck Bldg	
20c. TIME OF INJURY Month Day Year Hour a.m. 9 p.m. May 16 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Highway		20f. (City or town) (County) (State) Sweetair Baltimore Md.	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		22. DATE SIGNED 5/16/67	
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/19/67	
23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		23d. LOCATION (City or town) (County) (State) Long Green Balto. Md.	
24 FUNERAL DIRECTOR Leolard J. Ruck Inc. 5305 Harford Rd. #14		25a. REC'D BY REGISTRAR MAY 17 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles J. J...	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06242

06233

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER				d. STREET ADDRESS 713 Carolyn Road			
3 NAME OF DECEASED (Type or print) First AUGUSTA Middle DANGO Last DANGO				4 DATE OF DEATH Month May Day 17 , Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-1893	9. AGE (In years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months 1 Days 17 Hours 19 M.m.	11. IF UNDER 24 HRS Months 1 Days 17 Hours 19 M.m.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown - Huffins				14. MOTHER'S MAIDEN NAME Helen Kresh			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO 215-01-3179		17. INFORMANT Mrs. Elsie E. Bensinger, 713 Carolyn Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest secondary to old + DUE TO probably acute infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetic Mellitus (c) Diabetic Mellitus						INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 11, 1967 to May 17, 1967 , that (I) (we) lost the deceased alive on May 17, 1967 , and that death occurred at 10:45 A.M. from causes and on the date stated above.							
22a. SIGNATURE Ludilina M. Opeyza M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/17/67	
22c. PHYSICIAN'S NAME (Type) LUDILINA M. OPEYZA				22d. ADDRESS GBMC: 6701 N. Charles St. M.D. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-20-1967		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229				25a. REC'D BY REGISTRAR MAY 22 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06243

CERTIFICATE OF DEATH

06234

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission). a STATE MARYLAND b. COUNTY _____		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c LENGTH OF STAY IN 1b 364 DAYS	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE - 21229		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			d STREET ADDRESS 416 N. DENNISON STREET		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last DEWEY J. DANIEL			4 DATE OF DEATH Month Day Year MAY 2 19 67		
5 SEX MALE	6 COLOR OR RACE NEGRO	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/23/98	9 AGE (In years last birthday) yrs. 68	IF UNDER 1 YEAR Months Days Hours Min 19 67
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) PIPEFITTER		10b KIND OF BUSINESS OR INDUSTRY SHIP BUILDING		11 BIRTHPLACE (County & State, or foreign country) WELDON, NORTH CAROLINA	
12 CITIZEN OF WHAT COUNTRY? U.S.A.			13 FATHER'S NAME ELISHA DANIEL		
14 MOTHER'S MAIDEN NAME MARY ASH			15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		
16 SOCIAL SECURITY NO. 218 01 57 71		17 INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ENCEPHALOMALACIA AND GENERALIZED ARTERIOSCLEROSIS					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)		
21. I certify that XX (this hospital) attended the deceased from 5/3/66 , 19____, to 5/2/67 , 19____, that X (we) last saw the deceased alive on 5/2/67 , 19____, and that death occurred at 2:00P.M. from causes and on the date stated above.					
22a SIGNATURE <i>J. D. Talbert</i>			22b. DATE SIGNED 5/2/67		
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.			22d ADDRESS VAH FORT HOWARD, MARYLAND		
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 5-5-67	23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24 FUNERAL DIRECTOR		25a REG. BY REGISTRAR MORTEN & DYETT FUNERAL HOME		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
		ADDRESS 1701 LAURENS ST BALTIMORE, MD 4		MAY 4 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

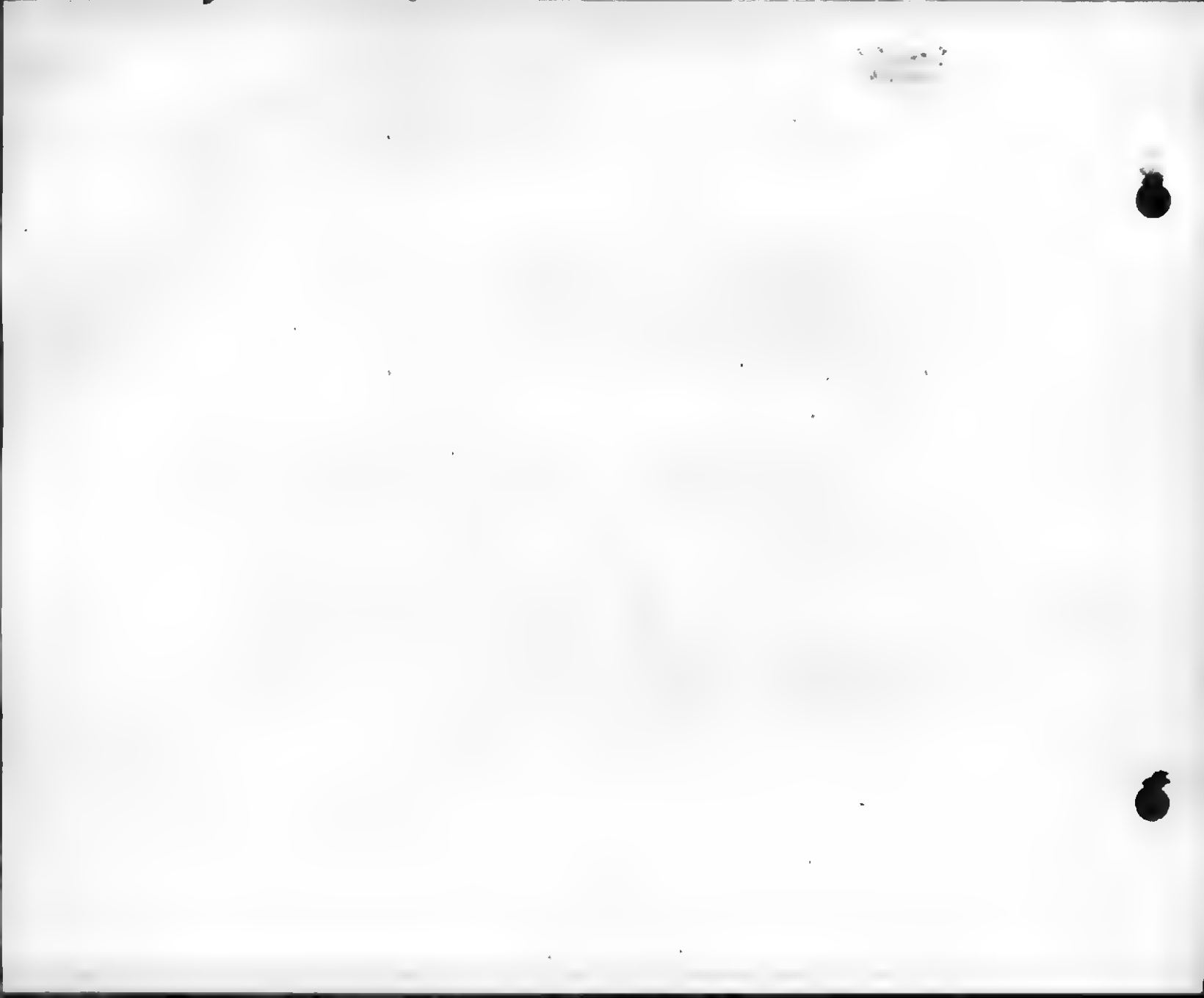
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06244

CERTIFICATE OF DEATH

05235

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Timonium	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor Nursing Home		d. STREET ADDRESS 205 Patann Road	
3. NAME OF DECEASED (Type or print) ROBERT L. DAVIS		4. DATE OF DEATH Month May Day 5 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-29-1893
9. AGE (In years last birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. County Commissioner	11. BIRTHPLACE (County & State, or foreign country) Penna.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Harry C. Davis	
14. MOTHER'S MAIDEN NAME Catherine		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 207123654A		17. INFORMANT Address Mrs. George Bell, 205 Patann Rd, Timonium-21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Colon with metastasis 58 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 27, 1967 , to May 5, 1967 , that (I) (we) last saw the deceased alive on May 5, 1967 , and that death occurred at 9:40 P.M. from causes and on the date stated above.			
22a. SIGNATURE A. Allan Spier		22b. DATE SIGNED 5/6/67	
22c. PHYSICIAN'S NAME (Type) Dr. A. Allan Spier		22d. ADDRESS 1501 Pentridge Rd, Balto, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation	23b. DATE THEREOF May 6, 1967	23c. NAME OF CEMETERY OR CREMATORY Greenmount	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc.-Baltimore, Md. - 14		25a. REC'D BY REGISTRAR MAY 8 1967	25b. REGISTRAR'S SIGNATURE Charles Young



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06245

00036

Item #9 Film #100 6/2/67

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b 1 mo. 10d. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 1610 Lyle Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROSE Middle MADE Last DAVIS				4. DATE OF DEATH Month MAY Day 29 Year 1967			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-17-70	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 2 Days 12 Hours Min.		11. BIRTHPLACE (County & State, or foreign country) SCOTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) SCOTH CAROLINA	
13. FATHER'S NAME Thos. Lewis				14. MOTHER'S MAIDEN NAME Addis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 219-01-3009		17. INFORMANT CARSON W. CLEGG, JR. Address 1610 Lyle Court	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) PNEUMONIA DUE TO (c) ETIOLOGY UNKNOWN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APRIL 19 , 19 67 , to MAY 29 , 19 67 , that (I) (we) last saw the deceased alive on APRIL 19 , 19 67 , and that death occurred at 3 59M , from the causes and on the date stated above.							
22a. SIGNATURE Morris Meiller				22b. DATE SIGNED 5/29/67			
22c. PHYSICIAN'S NAME (Type) MORRIS MEILLER M.D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5/24/67		23c. NAME OF CEMETERY OR CREMATORY London VA.		23d. LOCATION (City, town or county) (State) Baltimore	
24. FUNERAL DIRECTOR McCully - 337 ADDRESS Catapago Ave.				25a. REC'D BY REGISTRAR MAY 31 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reprove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

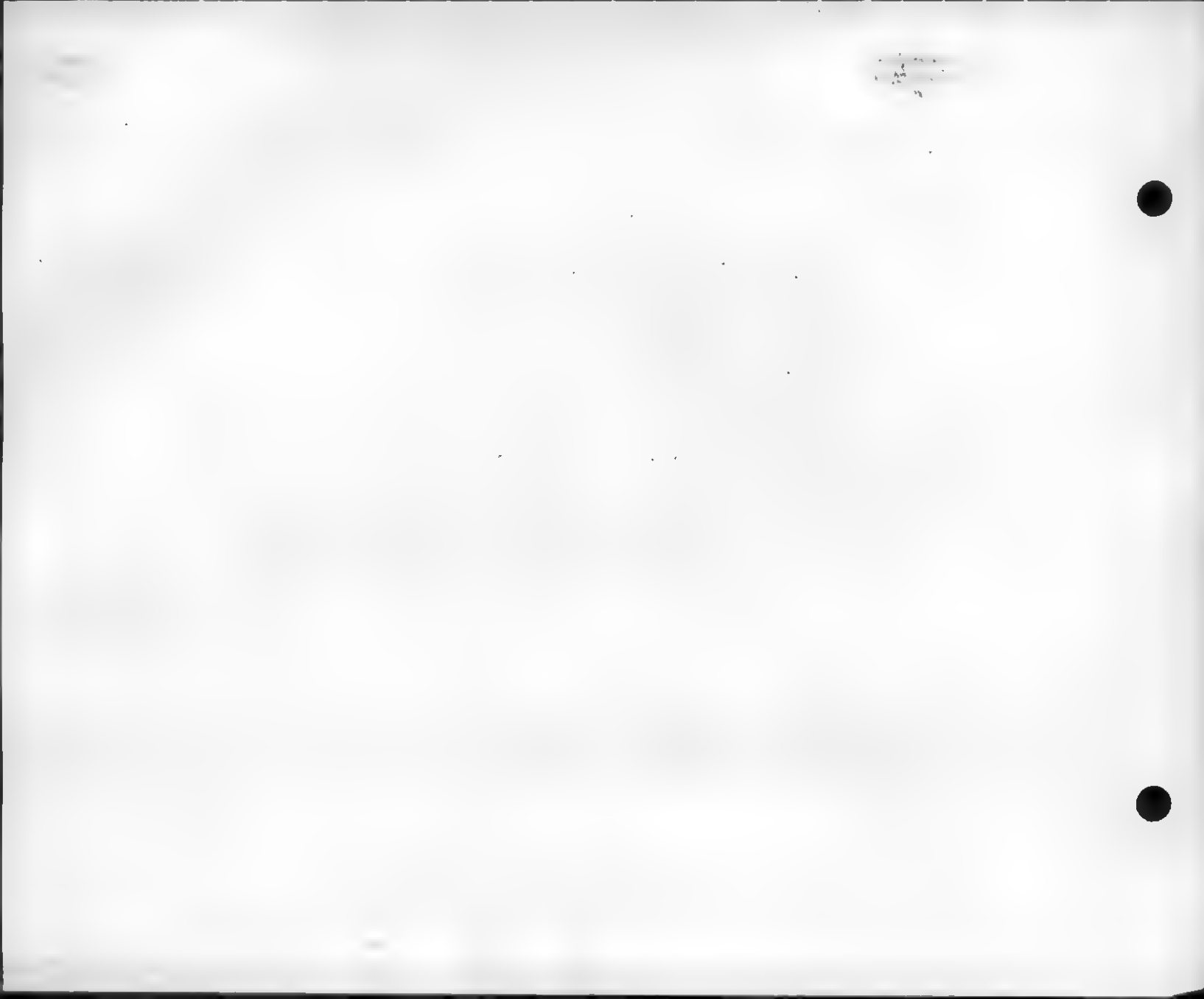
MD
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06246

CERTIFICATE OF DEATH

00237

1 PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD. b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS 119E WASHINGTON ST.	
3 NAME OF DECEASED (Type or print) First Middle Last LAWRENCE BERNARD DEE		4 DATE OF DEATH Month Day Year MAY 8 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 10-15-1906
9. AGE (In years lost birthday) 66 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN	
10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (County & State, or foreign country) MASS.	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME DELLAN DEE	
14. MOTHER'S MAIDEN NAME ELLEN FLYNN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown	
16. SOCIAL SECURITY NO 207-09-1046		17. INFORMANT Address Records, Mount Wilson State Hospital	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 72 Congestive heart failure DUE TO (b) Obstructive AIRWAYS DISEASE DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FAR ADV. PULMONARY TUBERCULOSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 7/24/12/1967	23c. NAME OF CEMETERY OR CREMATORY New Catholic Cemetery Baltimore, Md.	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR Power Funeral Home, Baltimore - 524		25. MAY 15 1967 DATE	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH

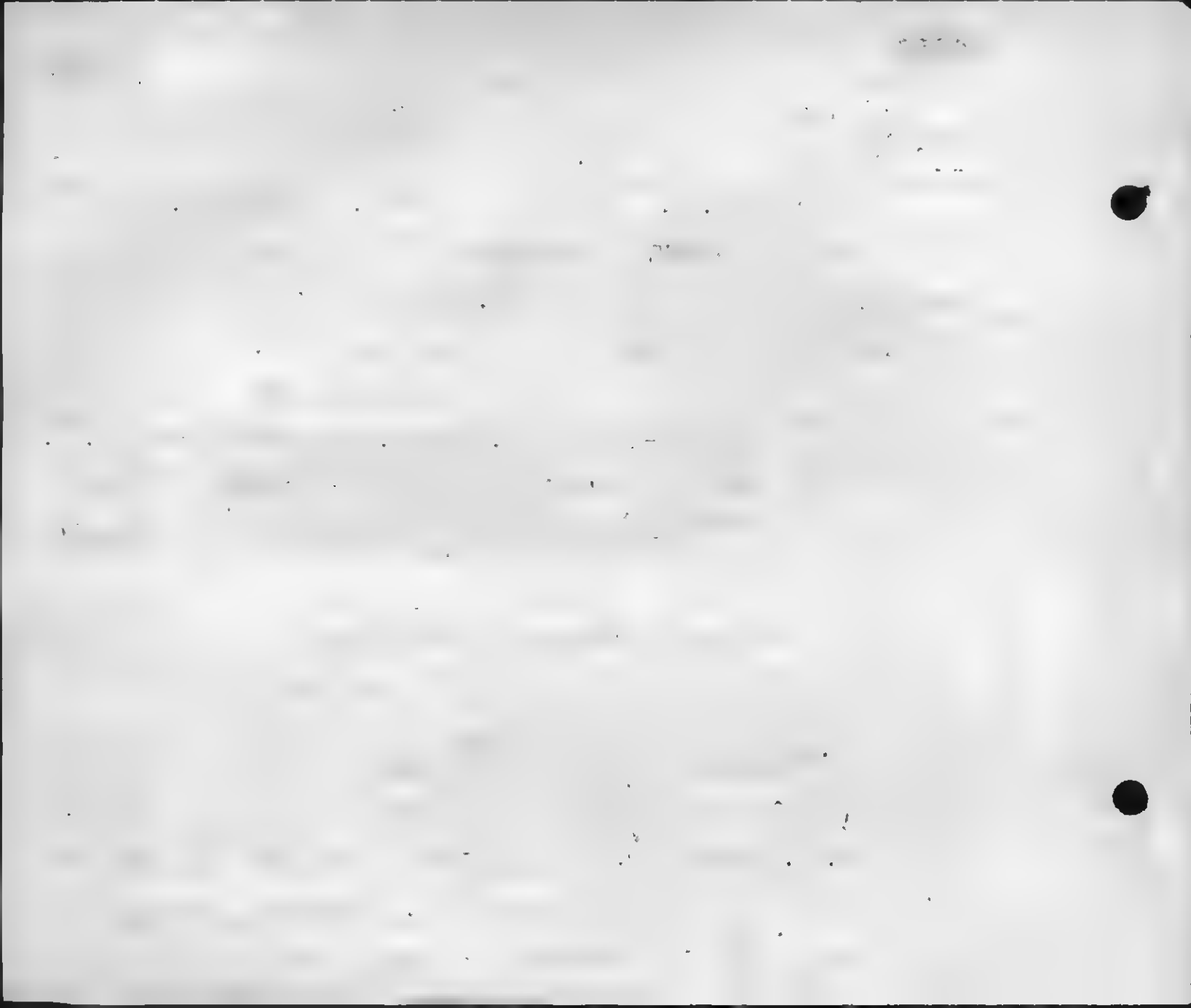
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06247

196738

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN TB 20 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 206 Tyrone Rd. N. 21212				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 206 N. Tyrone Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JESSIE LOUISE DEFIBAUGH				4. DATE OF DEATH Month May Day 24 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 24, 1880	
9. AGE (in years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 8 Days 10 Hours 15 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (County & State or foreign country) Uniontown, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Doran				14. MOTHER'S MAIDEN NAME Amanda Cup			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 214-07-1922D		17. INFORMANT Mrs. Helen D. Krause-206 Tyrone Rd. N.		Address 21212	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO ASCI D with a tual fibulation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Peripheral arterial Occlusion with Gangrene Right Hand DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Mass in abdomen (etiology)				INTERVAL BETWEEN ONSET AND DEATH 4 weeks 1 week			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Dr. H. Kammer attended the deceased from Sept. 1958 to May 1967 , that (I) last saw the deceased alive on 23 May 1967 and that death occurred at N. M. from the causes and on the date stated above.							
22a. SIGNATURE Wm. H. Kammer, Jr.				22b. DATE SIGNED 5/24/67		22c. PHYSICIAN'S NAME (Type) Wm. H. Kammer, Jr.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/27/67		23c. NAME OF CEMETERY OR CREMATORY Hill Crest Burial Pk.		23d. LOCATION (City, town or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George George Funeral Home - Cumberland, Md.				25a. REC'D BY REGISTRAR MAY 29 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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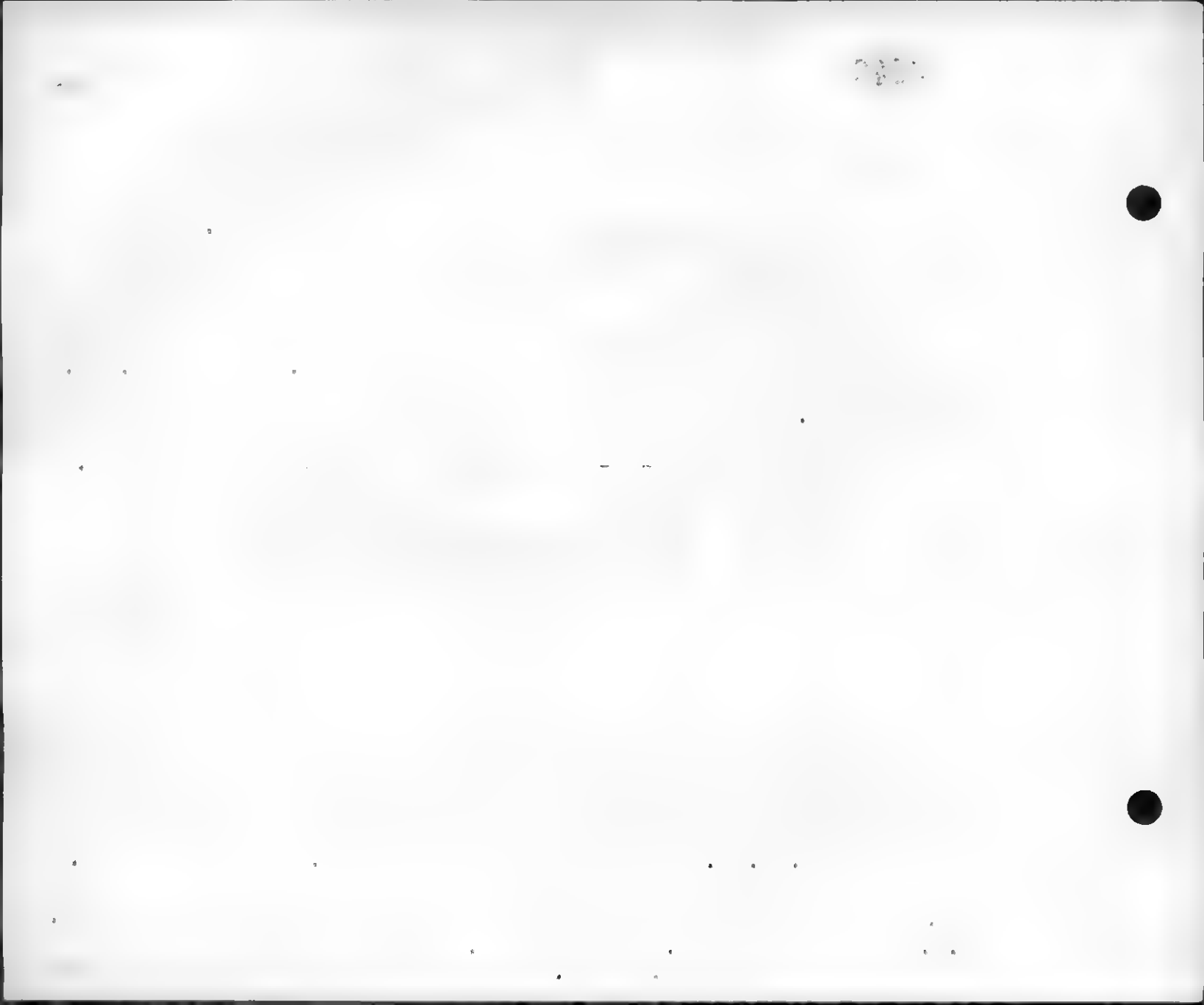
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06248

CERTIFICATE OF DEATH

06239

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. LENGTH OF STAY IN 1b 30-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor Nursing Home				d. STREET ADDRESS 3401 N. Charles St. 21218			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Boykin Dell				4. DATE OF DEATH Month Day Year May 19 19 67			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/14/1875		9. AGE (In years last birthday) 91 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Norfolk, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. Boykin				14. MOTHER'S MAIDEN NAME Elizabeth Whitehead Irwin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-54-6188		17. INFORMANT Address Bernard Boykin, 1919 Ruxton Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility, Arteriosclerosis, with 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Spinal cord complications DUE TO (c) Terminal Lobar Pneumonia						INTERVAL BETWEEN ONSET AND DEATH 29 years 2 weeks	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from 1/5/1938 to 5/19/1967 , that (1) was last saw the deceased alive on 5/18/1967 , and that death occurred at 4:55 A.M. from causes and on the date stated above.							
22a. SIGNATURE M.B. Levin				22b. DATE SIGNED 5/19/67		22c. PHYSICIAN'S NAME (Type) Dr. M. B. Levin	
22d. ADDRESS 218 E. University Pkwy.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem. Burial		23b. DATE THEREOF 5/24/1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Grove		23d. LOCATION (City or Town) (County) (State) Norfolk Va.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.				25a. REC'D BY REGISTRAR DATE MAY 22 1967		25b. REGISTRAR'S SIGNATURE J. Charles Jones	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06249

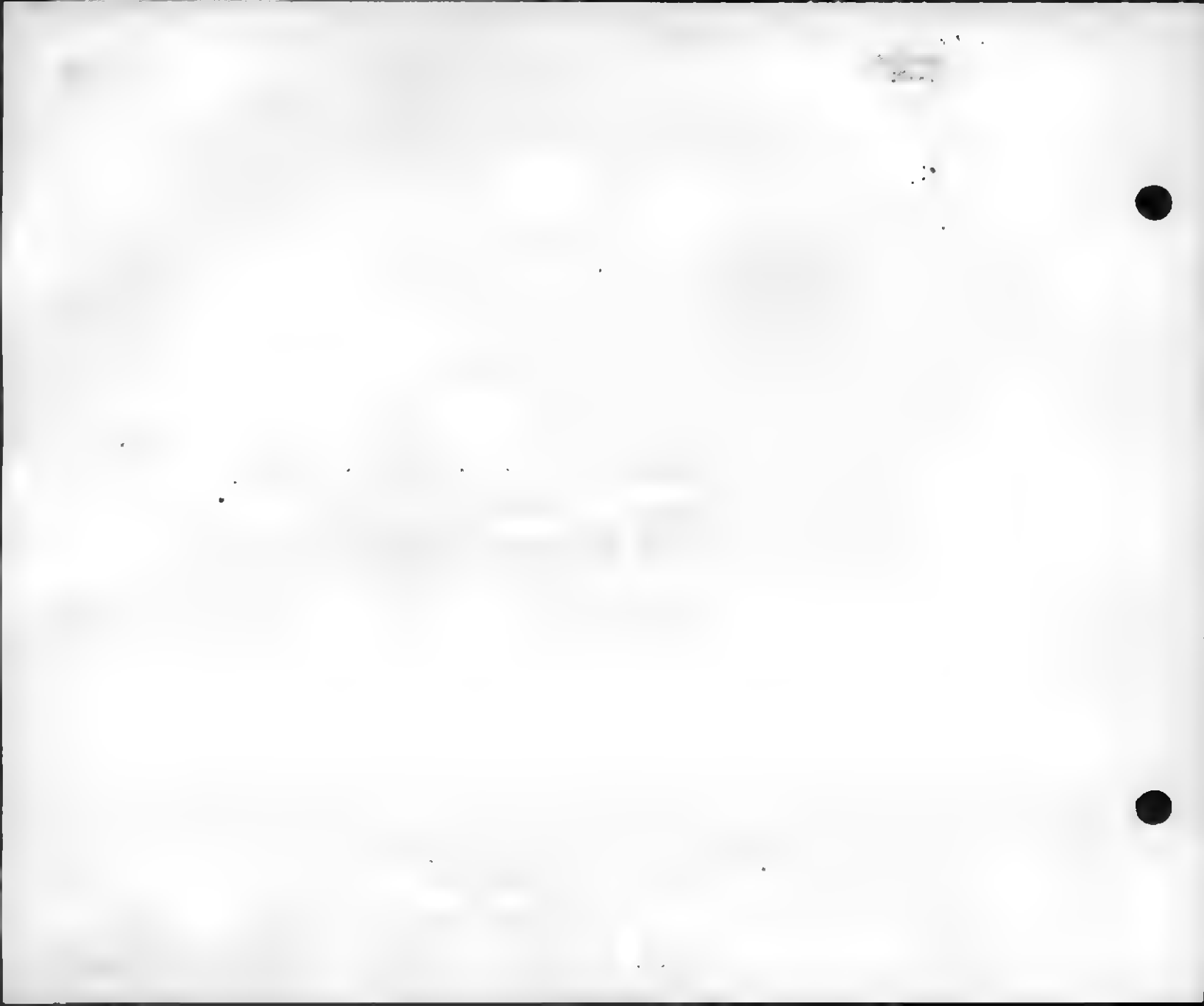
CERTIFICATE OF DEATH

05240


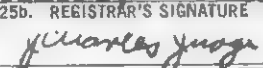
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. Maryland b. COUNTY	
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 1101 Kenilworth Drive 21204	
3. NAME OF DECEASED (Type or print) First Annie Middle L. Last De Prine		4. DATE OF DEATH Month 5 Day 5 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/13/1889
9. AGE (in years last birthday) 77		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Bauer		14. MOTHER'S MAIDEN NAME Marian D. Ellicott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 212 12 1661	
17. INFORMANT D. Mr. John L. DePrine		18. ADDRESS 1101 Kenilworth Drive.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Cerebral Arteriosclerosis with recent Cerebral DUE TO (c) Thrombosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/11 , 19 67 , to 5/5 , 19 67 , that (I) (we) last saw the deceased alive on 5/5 , 19 67 , and that death occurred at 3:50pM , from causes and on the date stated above.			
22a. SIGNATURE <i>Efraim L. R. eyes</i> M.D.		22b. DATE SIGNED 5/5/67	
22c. PHYSICIAN'S NAME (Type) Efraim L. R. eyes		22d. ADDRESS St. Joseph Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/9/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Maryland
24. FUNERAL DIRECTOR HENRY SANDER & SONS INC. BALTIMORE MD.		25a. REC'D BY REGISTRAR MAY 8 1967	25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																	
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 20 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Merridale d. STREET ADDRESS 632 Plymouth Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Rudolph Middle H. Last Dienhart				4. DATE OF DEATH Month May Day 9 Year 1967													
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 16, 1884		9. AGE (In years last birthday) 82 yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transportation Clerk				10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Julius J. Dienhart						14. MOTHER'S MAIDEN NAME Augusta E. Ehoff											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. George E. Russell, Jr. 179 Southview Rd.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH 15 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) this hospital attended the deceased from <u>Nov.</u>, 19<u>51</u>, to <u>May</u>, 19<u>67</u>, that (I) <u>yes</u> last saw the deceased alive on <u>May 6</u>, 19<u>67</u>, and that death occurred at <u>4:25 PM</u>, from the causes and on the date stated above.																	
22a. SIGNATURE 						22b. DATE SIGNED May 10, 1967		22c. PHYSICIAN'S NAME (Type) Leo J. Gaer									
22d. ADDRESS 1 Mallow Hill Ave., Baltimore, Md.																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-12-1967		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town or county) (State) Baltimore, Md.									
24. FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave.,						25a. REC'D BY REGISTRAR DATE MAY 11 1967		25b. REGISTRAR'S SIGNATURE 									



1
FOR STATE
HEALTH DEPT.

TO DEPUTY REGISTRAR: This certificate should be executed within 24 hours after death. If any information is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06251
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
06242

1. PLACE OF DEATH
a. COUNTY Balto
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
c. LENGTH OF STAY IN 1b life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St Joseph's Hosp, Towson 1654 E Belvedere
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 1654 E Belvedere
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) FREDERICK
4. DATE OF DEATH May 28 1967
5. SEX male 6. COLOR OR RACE W. 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH Dec 19 1897 69 yrs.
9. AGE (In years, last birthday) 69 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ice Plant Employee
11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Henry Dietz 14. MOTHER'S MARRIED NAME Wilhelmina Spielman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 212-12-0683A 17. INFORMANT Mrs Louise Roth 1654 E. Belvedere Avenue
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
(a) Hypertensive Arteriosclerotic Cardiovascular Disease
(b) Due to
(c) Ischemic Heart Disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year May 28 1967 20d. INJURY OCCURRED While ☒ Not While ☐ at work ☐ at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Baltimore (County) Co. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE Frank T. Kasik MD CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) FRANK T. KASIK MD M.D. ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ 9005 HARTFORD RD.
Address (Street, c'ty, town, or county)
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 5-31-1967 22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery 22d. LOCATION (City, town, or country) Baltimore (State) Md.
23. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road ADDRESS (36) 24a. REC'D BY REGISTRAR MA 31 1967 24b. REGISTRAR'S SIGNATURE Charles J. Jones



TO HOSPITAL OR ATTENDING PHYSICIAN: The low required that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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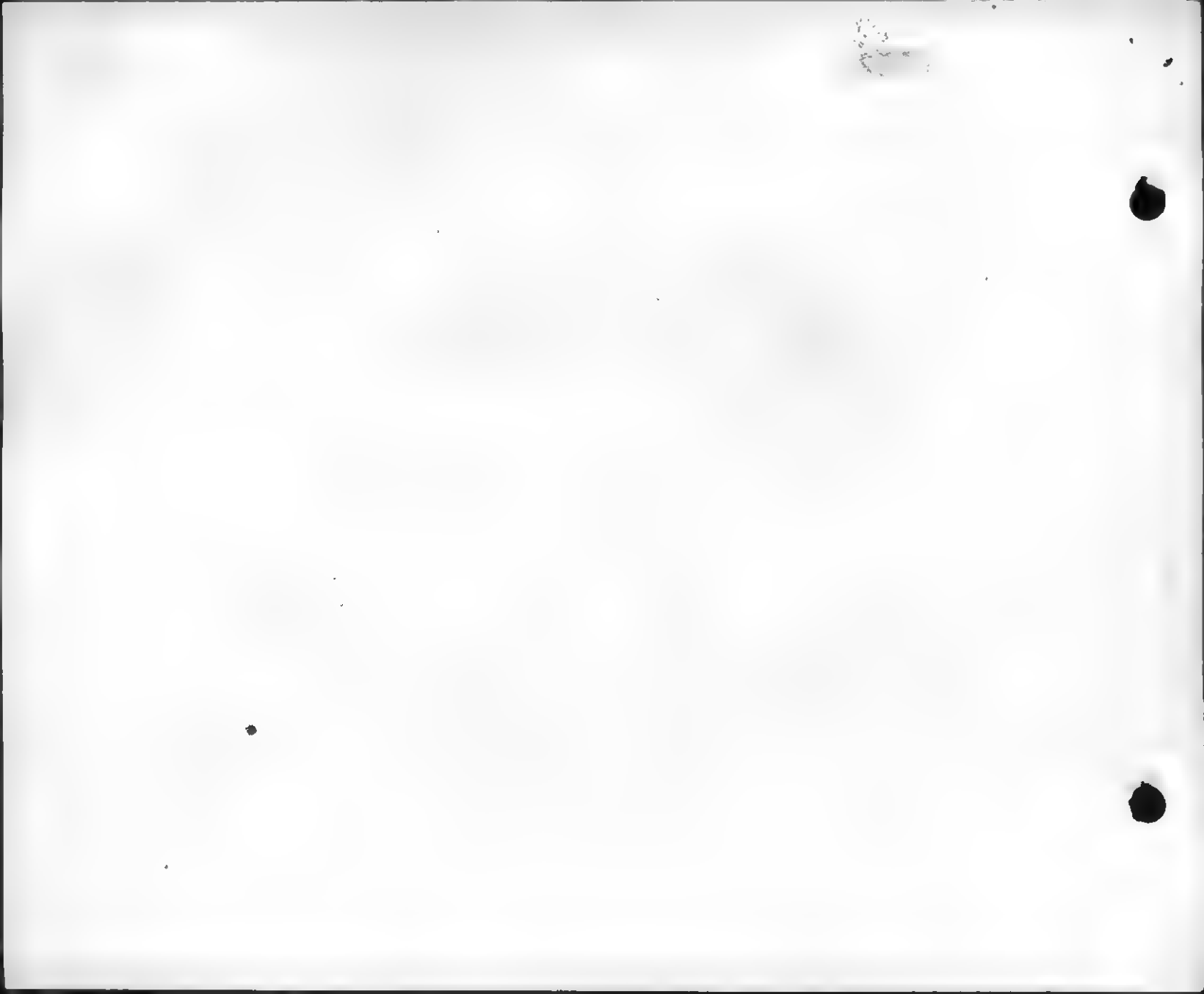
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06252

CERTIFICATE OF DEATH

00243

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 16 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE Maryland b. COUNTY Baltimore 21234 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234 d. STREET ADDRESS 8007 Jacqueline Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Mary Lucille DiFATTA		4 DATE OF DEATH Month Day Year May 16, 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH January 8, 1923
9 AGE (In years last birthday) 44 yrs		10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	10b. KIND OF BUSINESS OR INDUSTRY West Virginia
11 BIRTHPLACE (County & State, or foreign country) West Virginia		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin J Rowland		14 MOTHER'S MAIDEN NAME Madge Ramsey	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO Family RECORDS	
17 INFORMANT Family RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of the breast DUE TO (b) Pyelonephritis DUE TO (c) Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 28, 1967 , to May 16, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 16, 1967 , and that death occurred at 7:45 AM , from causes and on the date stated above.			
22a SIGNATURE Miles E. St. John M.D.		22b DATE SIGNED May 16, 1967	
22c PHYSICIAN'S NAME (Type) Miles St. John, M.D.		22d ADDRESS 7620 York Rd., Towson, Md. 21204	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)
Burial	5/18/67	Parkwood	Baltimore, Md.
24 FUNERAL DIRECTOR CHAS. F. EVANS & SON, INC Balto. Md.		25a REC'D BY REGISTRAR MAY 18 1967	25b REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06253		Item #2a, b, c & d in for, taken from prev. birth cert.				06207			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Medical Center</u>					d. STREET ADDRESS <u>804 Apt. H Wil-on Joint Road</u>				
3. NAME OF DECEASED (Type or print) <u>Baby Boy Diggins</u>					4. DATE OF DEATH <u>May 7 1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-7-67</u>		9. AGE (In years, last birthday) <u>6</u> yrs. <u>39</u> months <u>6</u> days <u>39</u> hours <u>39</u> min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <u>MARVIN PAUL Diggins</u>					14. MOTHER'S MAIDEN NAME <u>NANCY JOAN HARNER</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>Infant Birth information sheet</u>				
17. INFORMANT <u>Infant Birth information sheet</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY WITH PRIMARY APNOEA.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>POSSIBLE TRISOMY 16-18</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>5-7-</u> , 19 <u>67</u> , to <u>5-7-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-7-1967</u> 19, and that death occurred at <u>8:40 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>E. K. S. Narayanan</u> M.D.					22b. DATE SIGNED <u>5-7-1967</u>				
22c. PHYSICIAN'S NAME (Type) <u>E. K. S. NARAYANAN</u>					22d. ADDRESS <u>INTERN, GREATER BALTO. MED. CENTER.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>					23b. DATE THEREOF <u>5/8/67</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Greater Balto. Med. Ctr. Towson 4, Md.</u>					23d. LOCATION (City, town or county) (State)				
24. FUNERAL DIRECTOR <u>John E. Adams, M.D. ABULLC.</u>					25a. RECEIVED BY REGISTRAR <u>MAY 10 1967</u>				
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

06254

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06244

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE Maryland b COUNTY Baltimore			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Upperco P O				c LENGTH OF STAY IN 1b			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dark Hollow Road				e STREET ADDRESS Dark Hollow Road			
3 NAME OF DECEASED (Type or print) First Middle Last ANDREW Andrew DIGGS				4 DATE OF DEATH Month Day Year May 20 19 67			
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 10, 1894	9 AGE (In years day) yes 73	10 IF UNDER 1 YEAR Months Days Hours Min	11 IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Laborer		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY USA	
13 FATHER'S NAME Unknown Diggs				14 MOTHER'S MAIDEN NAME Annie Tucker			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16 SOCIAL SECURITY NO 217-24-7890 A			
				17 INFORMANT Address Mrs. Grace Thomas Baltimore, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Hypertensive and arteriosclerotic cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) DUE TO	
						(c) DUE TO	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute bronchopneumonia						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate		M.D. Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED May 21, 1967	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE OF DEATH May 24, 1967	23c NAME OF CEMETERY OR CREMATORY Piney Grove		23d LOCATION (City or town) (County) (State) Boring Md.		
24 FUNERAL DIRECTOR J. F. Elise & Sons		ADDRESS Reisterstown, Md.		25a REC'D BY REGISTRAR MAY 25 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06255

00245

1. PLACE OF DEATH

a. COUNTY

BALTIMORE

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

CATONSVILLE

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Summit Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

MARYLAND

b. COUNTY

Anne Arundel

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

EDGEWATER

d. STREET ADDRESS

R2 Box 29

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

ELSIE

First Middle Last

I. DOOLAN

4. DATE OF DEATH

Month

Day

Year

MAY 10 1967

SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

SEPT 1 1899

9. AGE (In years last birthday)

67 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (County & State, or foreign country)

WASH. DC.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

HERBERT GORDON

14. MOTHER'S MAIDEN NAME

EFFIE WASHINGTON WRIGHT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

MRS. THORN #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Cerebral Thrombosis left
Diabetes Mellitus
Emphysema Pulmonary
Artherosclerotic Cardiovascular
DISEASE

INTERVAL BETWEEN ONSET AND DEATH

40 days

3 1/2 hrs.

57 hrs.

57 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I. or Part II. of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 4/18/67 to 5/10/67, that (I) (we) last saw the deceased alive on 5/9/67, and that death occurred at 4:00 P.M. from the causes and on the date stated above

22a. SIGNATURE

W E Mc Grath

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

5/11/67

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

1303 Frederick Rd Catonsville 28 Md

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county)

(State)

CREMATION MAY 12 1967

FORT LINCOLN CREM.

PRINCE GEO. CO. MD.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

16 HUN M. TAYLOR, SON ANNAPOLIS MD.

DATE MAY 15 1967

J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Handwritten text, mostly illegible due to blurriness. Appears to be a list or series of notes.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item #9 Film #0339 6/5/67

06246

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

BALTIMORE

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

BALTIMORE 12

c. LENGTH OF STAY (in days)

2. USUAL RESIDENCE (Where deceased lived, if institution, list date of admission)

a. STATE

MD

b. COUNTY

BALTO.

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

TIMONIUM

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

REGISTER AVE + DORKING RD.

d. STREET ADDRESS

MAYS CHAPEL WOOD ROAD

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

FRANK

First

P

Middle

DUNLAP

Last

4. DATE OF DEATH

Month

Day

Year

MAY 27 1967

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

10-16-02

9. AGE (In years)

64

IF UNDER 1 YEAR

Months

Days

Hours

Min

IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Self course super.

10b. KIND OF BUSINESS OR INDUSTRY

Balto. Country Club

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

unknown dec'd

14. MOTHER'S MAIDEN NAME

unknown dec'd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

no

none

16. SOCIAL SECURITY NO

178-07-9552

17. INFORMANT

Family records

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

4

DUE TO

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

MYOCARDIAL INFARCTION

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

INTERVAL BETWEEN ONSET AND DEATH

10 YES

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY (Month, Day, Year, Hour, a.m., p.m.)

19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

Address (Street, City, town, or county)

DATE SIGNED

5-27-67

ACTUAL SIGNATURE

William A. Pinesbury

EXAMINER'S NAME (Type)

William A. Pinesbury

22a. BURIAL, CREMATION, REMOVAL (Specify)

burial

22b. DATE THEREOF

5/31/67

22c. NAME OF CEMETERY OR CREMATORY

Mays Chapel Cemetery

22d. LOCATION (City, town, or country)

Timonium, Balto. Co. Md.

(State)

23. FUNERAL DIRECTOR

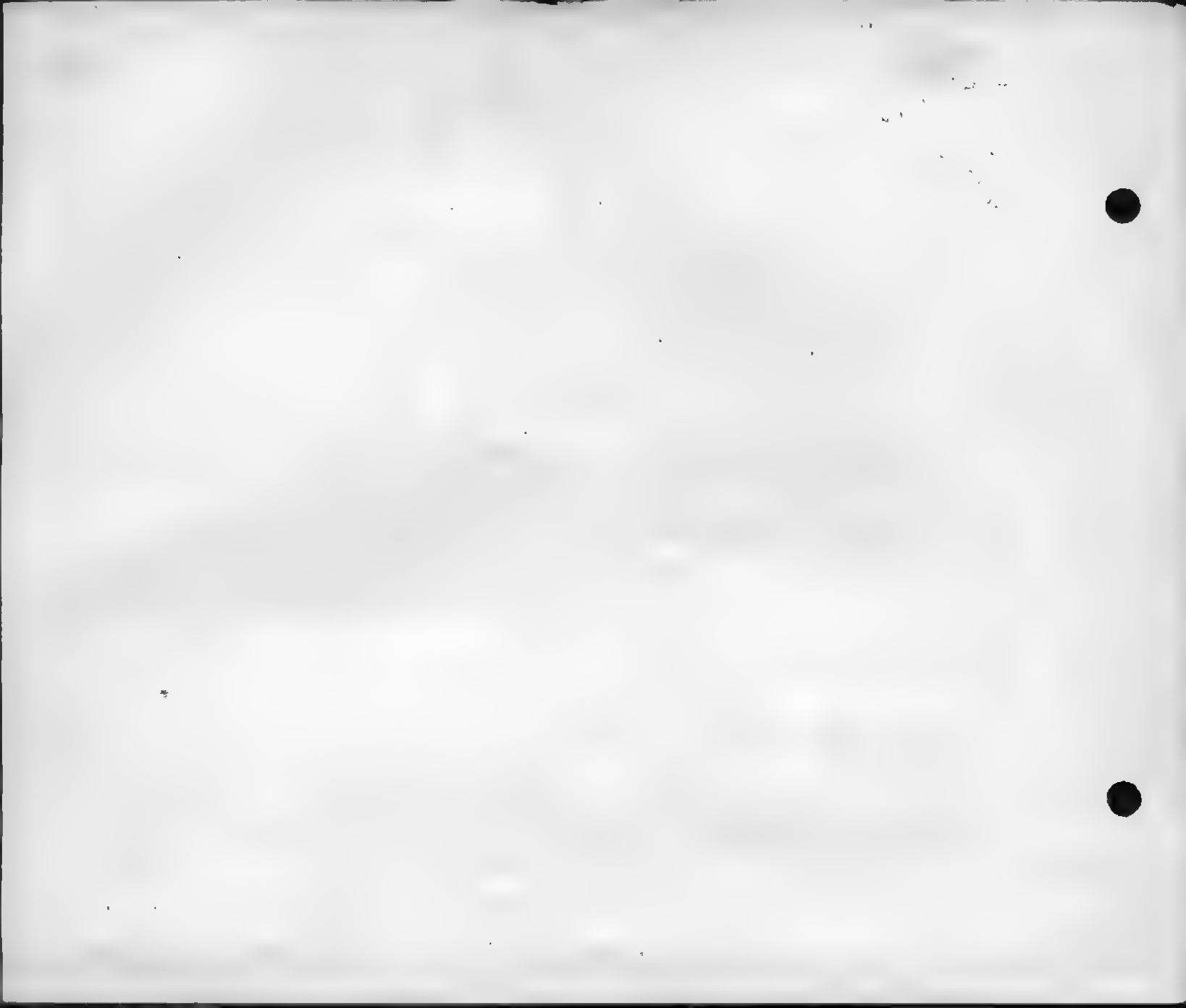
John Burns, 510-12 York Rd. Towson 21204

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE MAY 29 1967 Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06257

CERTIFICATE OF DEATH

00247

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HOME PARK, MD.		c. LENGTH OF STAY IN 1b 10-20-67	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center		d. STREET ADDRESS 1627 N. E. ST.	
3 NAME OF DECEASED (Type or print) First Thomas Middle NMN Last Early		4 DATE OF DEATH Month 5 Day 20 Year 1967	
5 SEX Male	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-13-13
9. AGE (In years last birthday) 13 yrs		10. IF UNDER 1 YEAR Months 1 Days 7 Hours 15 Min 00	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Foreman		10b. KIND OF BUSINESS OR INDUSTRY Retail Dairy	
11 BIRTHPLACE (County & State, or foreign country) ROCKERSVILLE TENN.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JAMES EARLY (DECEASED)		14. MOTHER'S MAIDEN NAME Mandy STUBBLEFIELD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO 408-28-4881	
17. INFORMANT Lula B. Early - same as #2 above		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ca. Lung X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-9-67 to 5/20/67 , that (I) (we) last saw the deceased alive on 5/20/67 , and that death occurred at 5/20/67 M, from causes and on the date stated above.			
22a. SIGNATURE R. K. CHILLAR		22b. DATE SIGNED 5/20/67	
22c. PHYSICIAN'S NAME (Type) RAM K. CHILLAR		22d. ADDRESS QTR. 13ALTO. MED. CENTER	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/23/67	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	23d. LOCATION (City or Town) (County) (State) Annapolis Md.
24. FUNERAL DIRECTOR Beverley E. Hopping		25a. REC'D BY REGISTRAR MAY 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

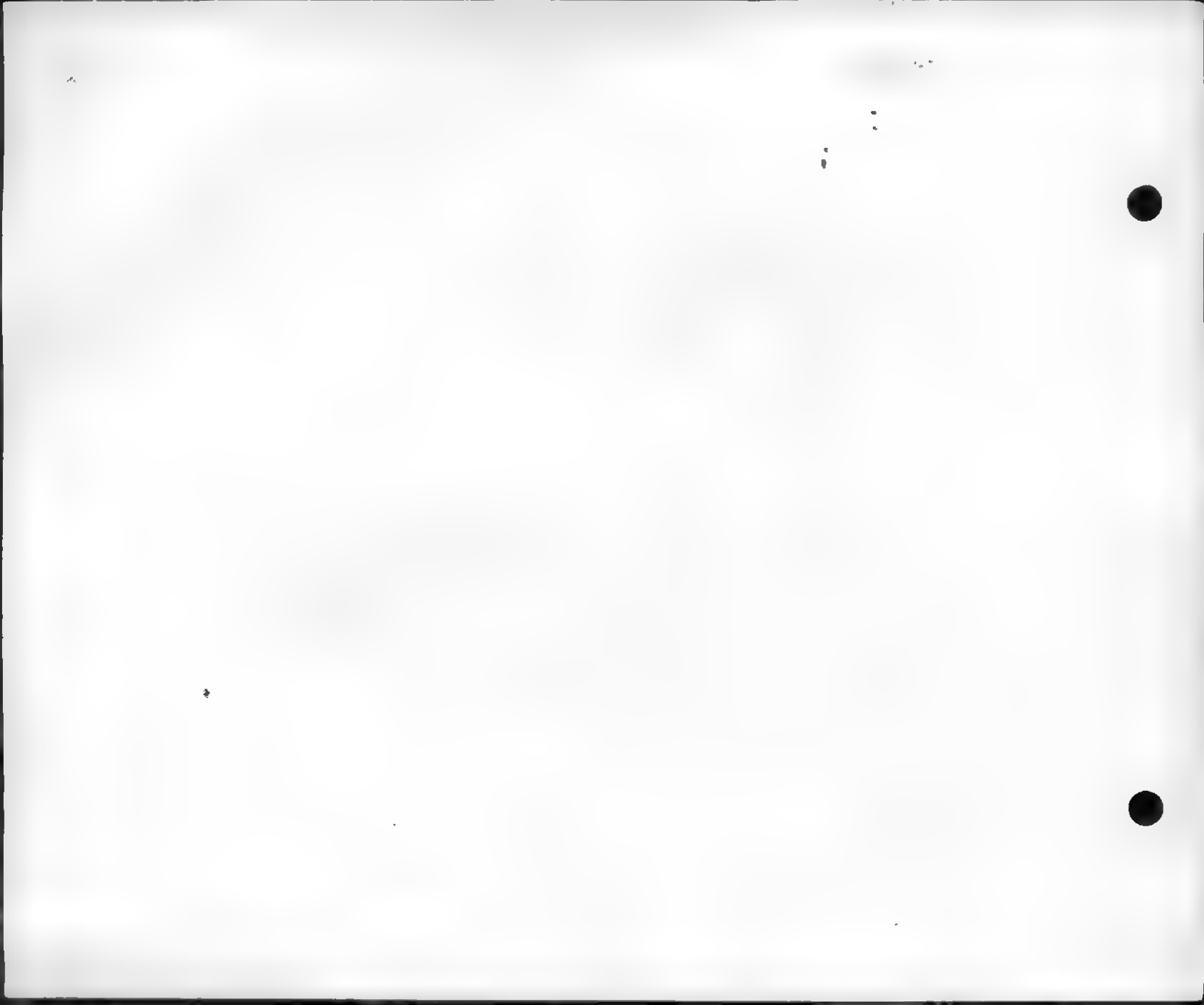
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06258

CERTIFICATE OF DEATH

00248

1 PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUMMIT HOME</u>		d. STREET ADDRESS <u>2119 ARLONNE DR.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>REA HOOPER EDGAR SR.</u>		4 DATE OF DEATH Month Day Year <u>MAY 13 1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6/22/91</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETI</u>	9 AGE (In years last birthday) <u>75</u> yrs
11 BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>MD.</u>	
13. FATHER'S NAME <u>WILLIAM EDGAR</u>		14. MOTHER'S MAIDEN NAME <u>MAMIE REA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>212 10 6420</u>	
17 INFORMANT <u>HELEN EDELMANN</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia due to</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Arteriosclerotic coronary disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>67</u> , to <u>13 May</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>13 May</u> 19 <u>67</u> , and that death occurred at <u>7</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>William J. Bryson</u>		22b. DATE SIGNED <u>15 May 67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. CO. MD</u>
24. FUNERAL DIRECTOR <u>E.S. MALNABB JR.</u>		25a. REC'D BY REGISTRAR <u>MAY 16 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>301 FREDERICK ST. BALTO. MD 21201</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06259

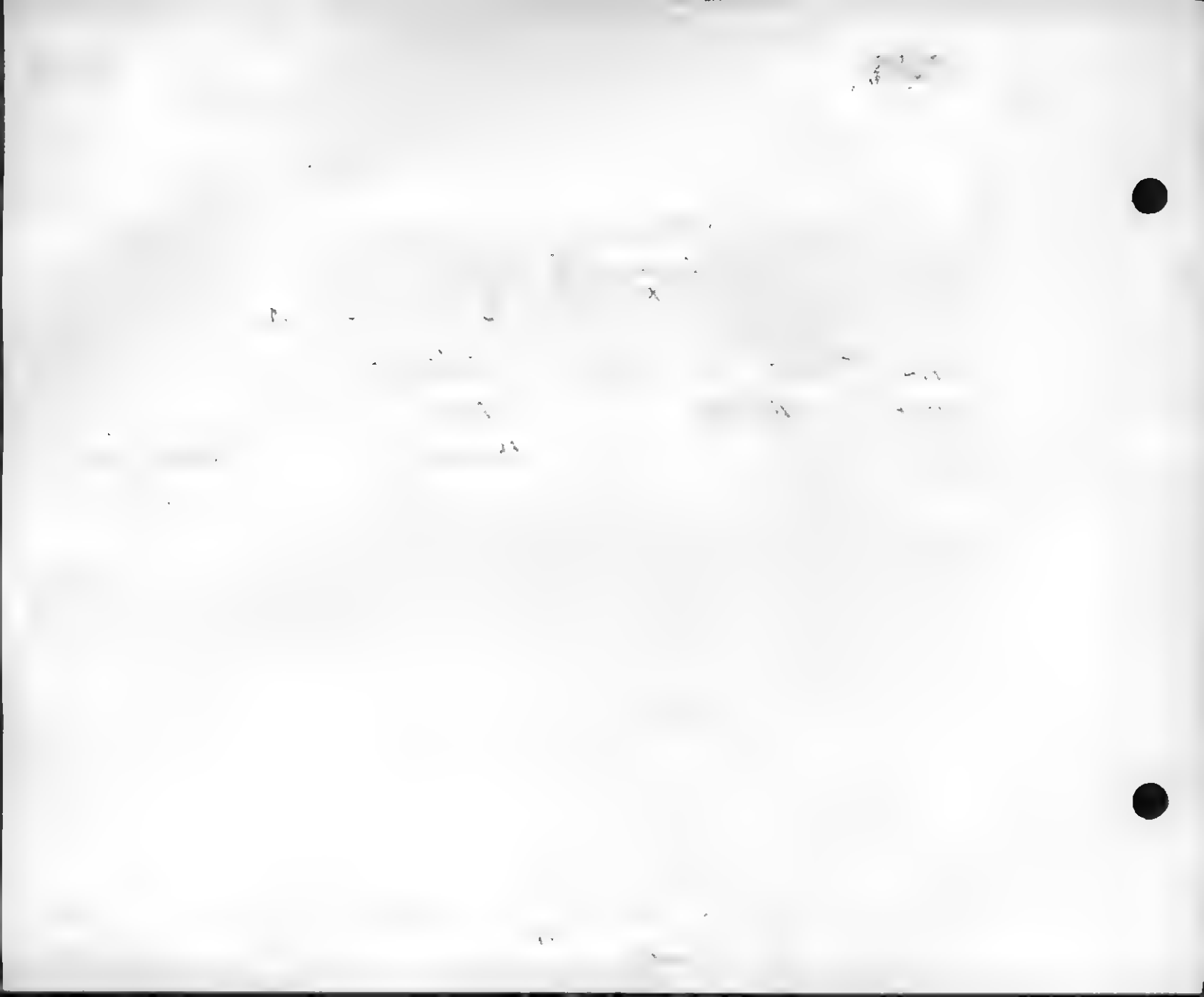
06249

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hillendale Country Club		d. STREET ADDRESS 1202 Cherry Hill Road	
3 NAME OF DECEASED (Type or print) First WILL Middle LEONARD Last ELLERBE		4 DATE OF DEATH Month May Day 11 Year 19 67	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-14-1926
9 AGE (in years last birthday) 41 yrs		10 IF UNDER 1 YEAR Months 11 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10b. KIND OF BUSINESS OR INDUSTRY CONST.	
11 BIRTHPLACE (State or foreign country) ELLERBE, N.C.		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME JOSHUA ELLERBE		14 MOTHER'S MAIDEN NAME MINNIE HINES	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO	
17. INFORMANT Lydia Ellerbe		Address 1202 Cherry Hill Rd.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive and Arteriosclerotic Cardiovascular Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) 443A DISEASE			INTERVA. BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town, (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty		22. DATE SIGNED 5/11/67	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/16/67	23c. NAME OF CEMETERY OR CREMATORY Corner MEM. Park Laurel Md.
24. FUNERAL DIRECTOR Milton E. Edickson		25a. REC'D BY REG. STRAR DATE MAY 12 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 4 Filed 5/29/67 kk

06260

CERTIFICATE OF DEATH

06250

1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LUTHERVILLE</u>			c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LUTHERVILLE</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>16 E. SEMINARY AVE.</u>				d. STREET ADDRESS <u>16 E. SEMINARY AVE.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>E.</u> Last <u>ENDERS</u>				4 DATE OF DEATH Month <u>MAY</u> Day <u>1</u> Year <u>1967</u>				
5 SEX <u>FEMALE</u>		6 COLOR OR RACE <u>WHITE</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>FEB. 1 - 1895</u>		
9 AGE (In years lost birthday) <u>72</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min				
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11 BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Charles Wells - (Step Father)</u>				14 MOTHER'S MAIDEN NAME <u>Henrietta E. Wells</u>				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> <u>NONE</u>			16 SOCIAL SECURITY NO. <u>—</u>		17 INFORMANT <u>Family Records</u> Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> DUE TO (b) <u>Diabetes & Arteriosclerosis C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Coronary Thrombosis</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Severe Months</u>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)					
20c TIME OF INJURY Month, Day, Year Hour <u>—</u> a.m. <u>—</u> p.m. <u>19</u>			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>many years</u> , 19 <u>—</u> , that (I) (we) last saw the deceased alive on <u>Apr 29</u> 19 <u>67</u> , and that death occurred at <u>—</u> M, from causes and on the date stated above.								
22a SIGNATURE <u>George McLean</u>				22b DATE SIGNED <u>5/4/67</u>		22c PHYSICIAN'S NAME (Type) <u>GEORGE McLEAN</u>		
22d ADDRESS <u>705 Med Out Bldg</u>				22e MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
<u>BURIAL</u>		<u>MAY 5, 1967</u>		<u>Prospect Hill Cemetery</u>		<u>Towson, Md.</u>		
24 FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>				25b REC'D BY REGISTRAR <u>MAY 8 1967</u>		25c REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 13
6M 1/67

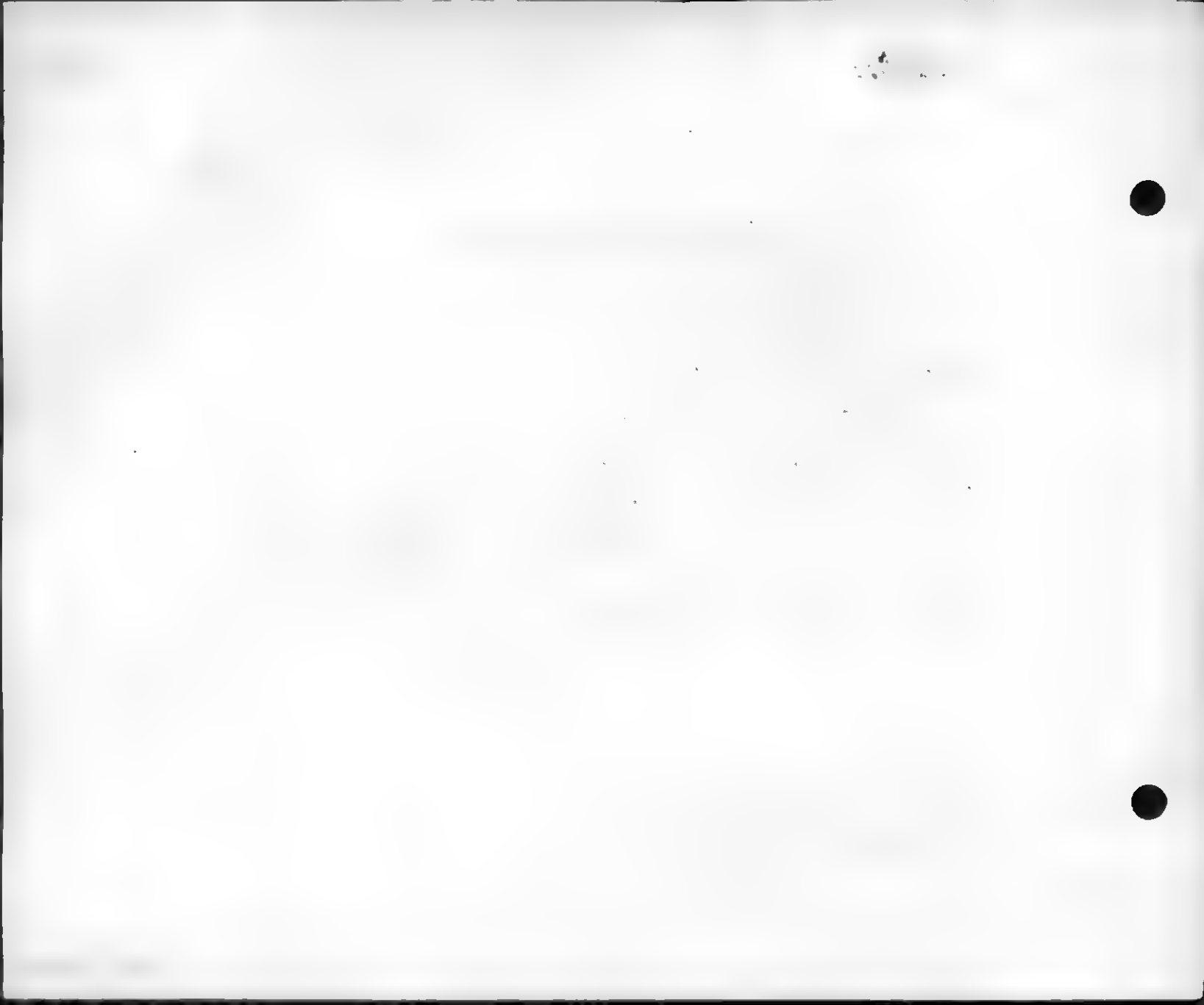
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06261

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06251

1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MD.</u> b COUNTY <u>BALTO.</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE-RIVER</u>				c LENGTH OF STAY IN 1b <u>30 YRS.</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2200 OLD CREMS RD.</u>				e STREET ADDRESS <u>2200 OLD CREMS RD.</u>			
3 NAME OF DECEASED (Type or print) <u>HARRY CHARLES EVANS SR</u>				4 DATE OF DEATH <u>MAY 10 19 67</u>			
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-6-1894</u>	9 AGE (In years last birthday) <u>72</u> yrs	F UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER-RET MARTIN-CO</u>				10b KIND OF BUSINESS OR INDUSTRY <u>MD</u>		11 BIRTHPLACE (State or foreign country) <u>MD</u>	
13 FATHER'S NAME <u>HARRY C EVANS</u>				14. MOTHER'S MAIDEN NAME <u>WERNER</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WWI</u>				16 SOCIAL SECURITY NO <u>216-10-6063A</u>		17 INFORMANT <u>Florence Evans</u> Address <u>SAME</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>A-S-C-V-Disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW NATURE OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>None</u>			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town)				20g (County)		20h (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M. B. Davis</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. DAVIS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a B. RIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b DATE THEREOF <u>5/13/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>PARK WOOD Cem.</u>	
24 FUNERAL DIRECTOR <u>J. G. CONNELLY SONS</u>				ADDRESS <u>300 MACE</u>		25a REC'D BY REGISTRAR <u>MAY 15 1967</u>	
23d LOCATION (City or town) <u>BALTO</u>				23e (County) <u>MD.</u>		23f (State) <u>MD.</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>				22.1 DATE, SIGNED <u>5/11/67</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06262

06252

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE M Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halifax	
c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph, Hospital		d. STREET ADDRESS Rt #1, Box 568	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First ANNIE Middle MAUDE Last FARMER		4. DATE OF DEATH Month May Day 26 Year 19 67	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-26-94
9. AGE (In years last birthday) 72 yrs		10 UNDER 1 YEAR Months Days	11 UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lee Divers		14. MOTHER'S MAIDEN NAME Martha Dillon	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO	
17 INFORMANT H. Melvin Farmer		Address 1410 Tenbury Rd. 21903	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro vascular thrombosis, right cerebral artery DUE TO (b) Possible pulmonary embolism and infarction DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-12 , 1967 to 5-26 , 1967 , that (I) (we) last saw the deceased alive on 5-26 , 1967 , and that death occurred at 4:35 P.M. from causes on and on the date stated above.			
22a SIGNATURE <i>Fiorella G. Malit</i>		22b DATE SIGNED 5-26-67	
22c PHYSICIAN'S NAME (Type) Fiorella G. Malit, M.D.		22d ADDRESS 7620 York Road, Baltimore, Md. 21204	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 5/29/67	23c NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery	23d LOCATION (City or Town) (County) (State) Halifax, Va.
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson 1050 York Rd. 21204		25a REC'D BY REGISTRAR DATE MAY 29 1967	
		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06263

CERTIFICATE OF DEATH

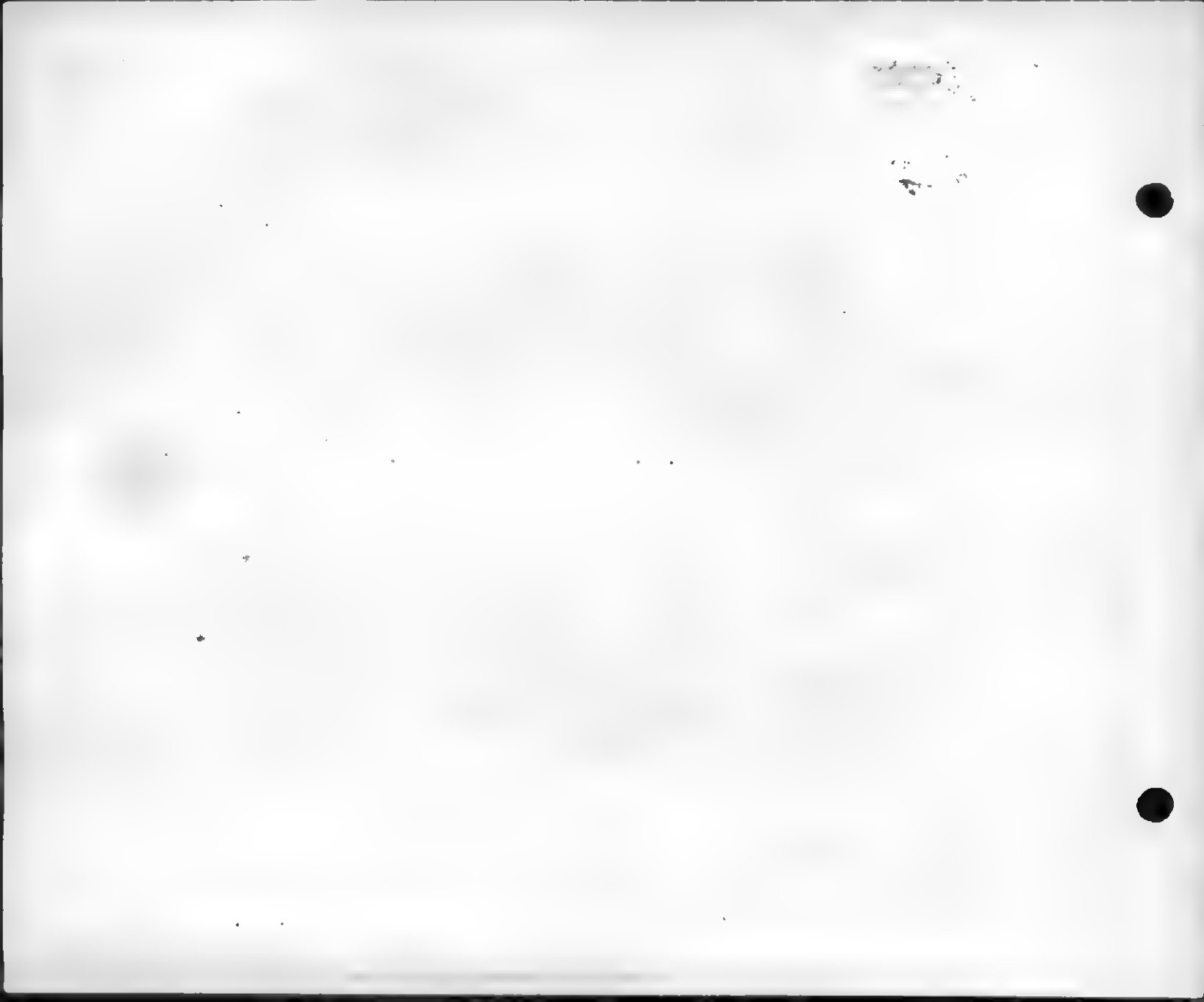
06253

Item 2 Film 4309 1/1/67 kk

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>10 MONTHS</u>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SHANGRI-LA NURSING HOME</u>		d. STREET ADDRESS <u>2279 Park Hill Avenue</u> <u>3813 HARLEM AVE</u>	
3 NAME OF DECEASED (Type or print) <u>MARY FAUBLE</u>		4 DATE OF DEATH Month <u>MAY</u> Day <u>4</u> Year <u>1967</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>CAU</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/27/1889</u>
9 AGE (In years last birthday) <u>80</u> yrs.		10 IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>UNKNOWN</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>UNKNOWN John Redlin</u>		14 MOTHER'S MAIDEN NAME <u>UNKNOWN Annie Kline</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>W. D.123-038</u>	
17. INFORMANT <u>Linthicum, Md.</u> <u>Mr. Melvin F. Fauble 516 Springer Court</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral anoxia to road failure.</u> <u>441X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Malignant hypertension.</u> DUE TO (c) <u>AS CVD & Chronic Cerebral.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1. Chronic hypertension, systemic crisis.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/26</u> , 19 <u>66</u> , to <u>5/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/4/67</u> , 19 <u>67</u> , and that death occurred at <u>11:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Arasthmo M. Arasthmo</u> M.D.		22b. DATE SIGNED <u>5/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arasthmo M. Arasthmo</u>		22d. ADDRESS <u>8155 Loch Raven Blvd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 6, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cen.</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto. Md.</u>
24 FUNERAL DIRECTOR <u>G. Truman Schwab 3512 Frederick Ave, Balto. Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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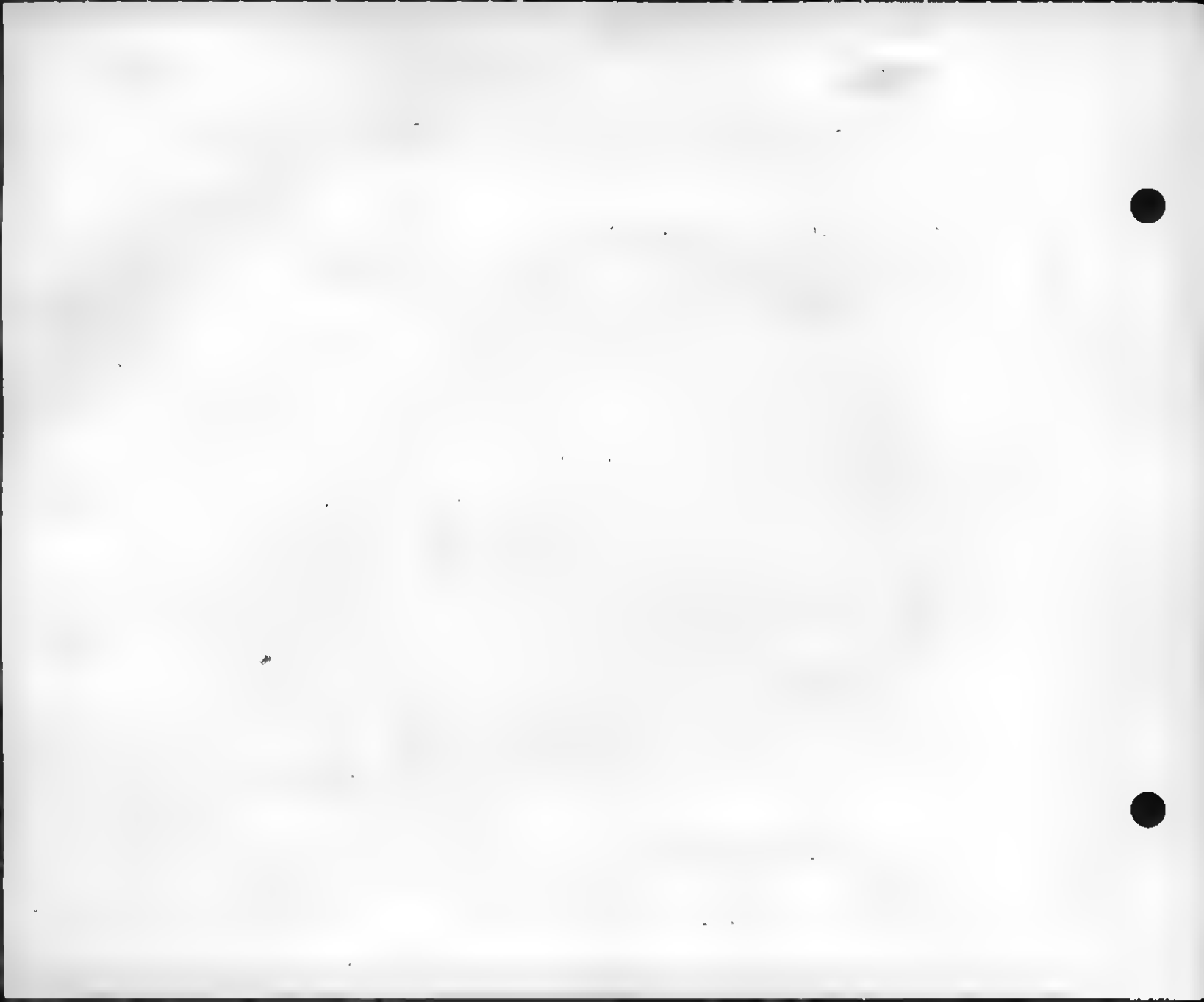
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06264

06254

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN Tb 7 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 7524 Belair Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH FRANK FAULSTICH			4. DATE OF DEATH Month Day Year May 16 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/20/16		9. AGE (In years last birthday) 51 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician		10b. KIND OF BUSINESS OR INDUSTRY Maritime Adminis.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Henry Faulstich			14. MOTHER'S MAIDEN NAME Steidle Caroline		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 215-05-5260		17. INFORMANT Patient's Chart Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure due to DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 2 days
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Greater Baltimore Medical Center	
20f. (City or town) Baltimore		20g. (County) Baltimore		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 5/9/ , 1967, to 5/16 , 1967, that (I) (we) last saw the deceased alive on 5/16 , 1967, and that death occurred at 9:27AM , from causes and on the date stated above.					
22a. SIGNATURE <i>John E. Adams</i>		22b. DATE SIGNED May 16, 1967		22c. PHYSICIAN'S NAME (Type) John E. Adams	
22d. ADDRESS Greater Baltimore Medical Center		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 14, 1967		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
23d. LOCATION (City or town) Baltimore		23e. (County) Baltimore		23f. (State) Md.	
24. FUNERAL DIRECTOR DIPPEL BROS INC 7110 BELAIR ROAD		25a. REC'D BY REGISTRAR MAY 18 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06265

CERTIFICATE OF DEATH

06265

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverview				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 914 Winsap Court, Riverview, Md. 21227				d. STREET ADDRESS 914 Winsap Court			
3. NAME OF DECEASED (Type or print) First William Middle J. Last Faulstich				4. DATE OF DEATH Month May Day 12 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/16/92		9. AGE (In years last birthday) 75 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Faulstich				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 213-05-5091		17. INFORMANT Mrs. Herma C. Parsons Address 914 Winsap Court		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Carcinoma from DUE TO (c) Large Bowel							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 30, 1967 to May 12, 1967 , that (I) (we) last saw the deceased alive on May 12, 1967 , and that death occurred at 8:00 A.M. , from causes and on the date stated above.							
22a. SIGNATURE Domingo C. Sorongon					22b. DATE SIGNED 5/13/67		
22c. PHYSICIAN'S NAME (Type) DOMINGO C. SORONGON M.D.					22d. ADDRESS 3915 HOLLINS FERRY RD. BALTO., Md. 21227		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/15/67		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard				4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR MAY 15 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

1920



FOR STATE
HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
5M 1/65

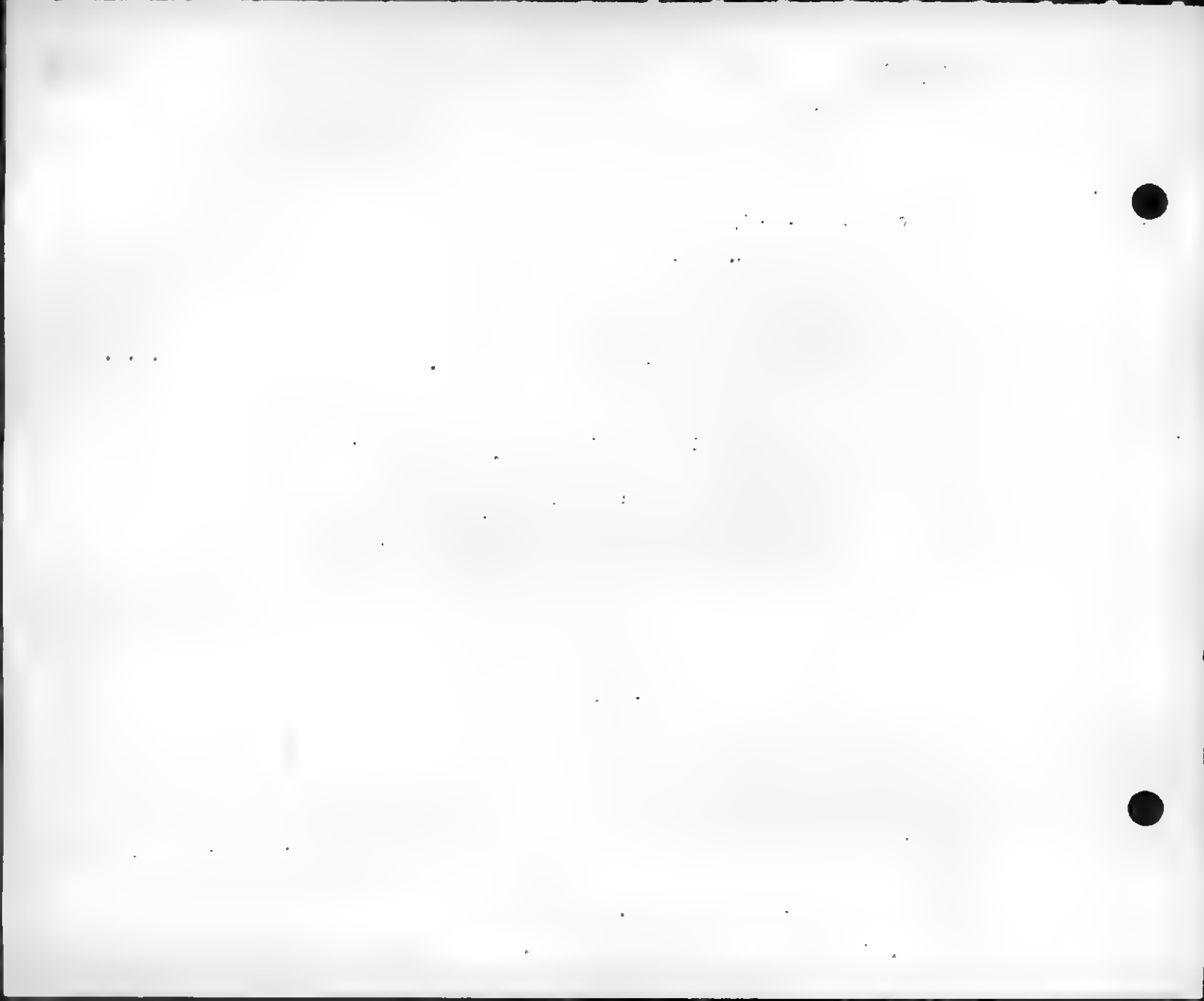
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06266

06256

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sparrows Point c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bethlehem Steel Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE 820 Belnord Ave b. COUNTY 21224 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore Md d. STREET ADDRESS Sparrows Point Md e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leo B Filipiak First Middle Last 4. DATE OF DEATH May 6 1967 19 Month Day Year		5. SEX M/W 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 9 22 10 9. AGE (in years last birthday) 56 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roll Shop Helper 10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Poland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stefan		14. MOTHER'S MAIDEN NAME Josephine Benger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213 07 7070	
17. INFORMANT Mrs. Florence Filipiak		Address same	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) A-S-C-V. DISEASE DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M B Daur EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, county, state) 522 N. 2nd St. Baltimore Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5 11 67	
23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR Raymond L. Kaczorowski		ADDRESS 2525 Fleet St. 21224	
25a. REC'D BY REGISTRAR MAY 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

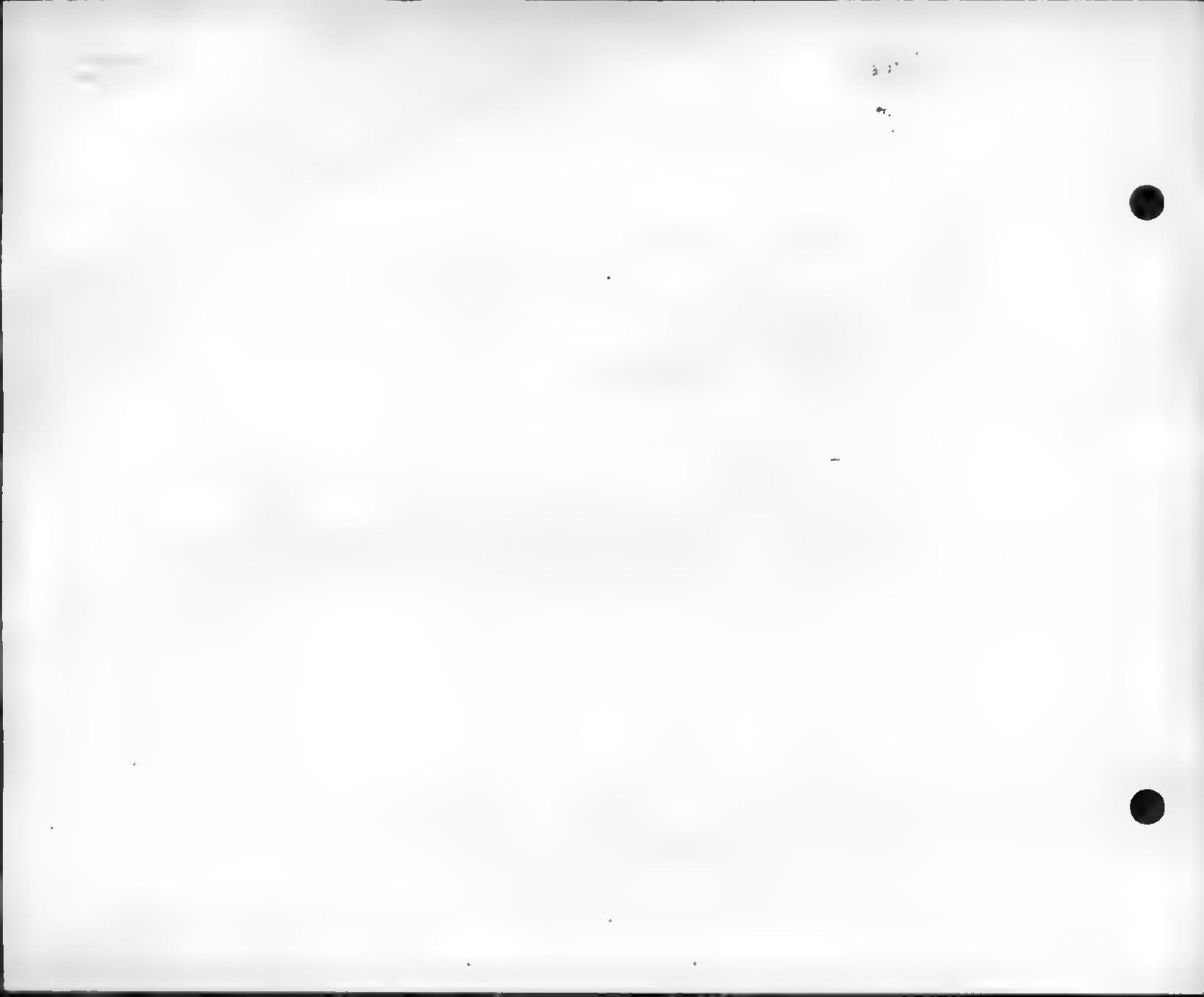
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06267

CERTIFICATE OF DEATH

06257

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville 21087 d. STREET ADDRESS Bellvue Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary G. FITZPATRICK		4. DATE OF DEATH Month Day Year May 16, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 17, 1899
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Field		14. MOTHER'S MAIDEN NAME Margaret Parrish	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-38-7693	
17. INFORMANT Margaret F. Langrehr		Address Bellvue Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Myocardial infarction with aneurysmal dilation of the heart DUE TO (c) of the heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) Diabetes mellitus			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 10, 19 67 , to May 16, 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 16, 19 67 , and that death occurred at 9:30 P.M. from causes and on the date stated above			
22a. SIGNATURE Juana S. Cockburn M.D.		22b. DATES SIGNED May 17, 1967	
22c. PHYSICIAN'S NAME (Type) Juana S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 19, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Francis Cemetery	23d. LOCATION (City or Town) (County) (State) Abingdon, Maryland
24. FUNERAL DIRECTOR The Dippel Bro's Inc. 7110 Belair Rd.		25a. REC'D BY REGISTRAR MAY 19 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute this certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 (page 5) may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

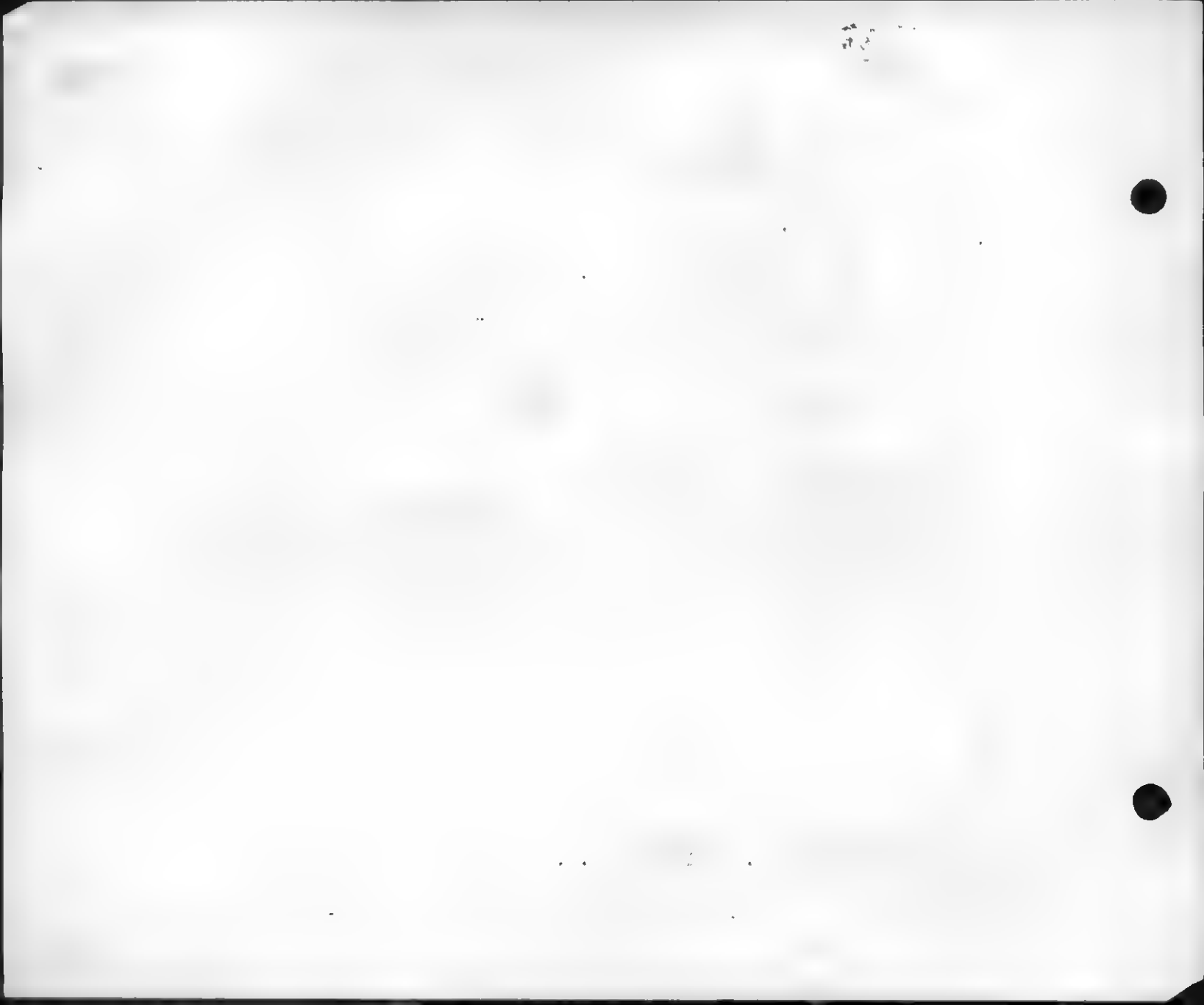
Items 18-21 Film 389 6-12 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06268

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06258

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution) Reside in hospital admission a STATE Maryland b COUNTY BALTIMORE			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Belair				c LENGTH OF STAY IN b 15 min.			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 43 W. Hicham Road				d. STREET ADDRESS Hays 108 Hays Street			
3 NAME OF DECEASED (Type or print) First Middle Last JAMES D. FLANAGAN				4 DATE OF DEATH Month Day Year May 21, 19 67			
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> D VORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 6-25-43	9 AGE (In years last birthday) 23 yrs	10 FUND 1 YEAR Months Days Hours Min	11 FUND 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b KIND OF BUSINESS OR INDUSTRY Loan Co.		11 BIRTHPLACE (State or foreign country) Austinville, Va.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Steve Flanagan				14. MOTHER'S MAIDEN NAME Bertha M. Shupe			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 229-54-7997		17. INFORMANT Address Steve Flanagan, Austinville, Va.			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contact gunshot wound of head 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18, Shot self in head					
20c TIME OF INJURY Month, Day, Year 3:00 p.m. 5-21 19 67	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f (City or town), (County) (State) Baltimore Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Sprongate		M.D. Charles S. Sprongate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED May 21, 1967	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town or county)	
23a BURIAL CREMATION, REMOVAL (Specify) Removal	23b DATE THEREOF May 23, 1967	23c NAME OF CEMETERY OR CREMATORY Vaughan, Wynn, McGrady F.H.		23d LOCATION (City or town) (County) (State) Hillsville Carroll Va			
24 FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009		ADDRESS		25a MAY 24 1967		25b PREPARE'S SIGNATURE John S. Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

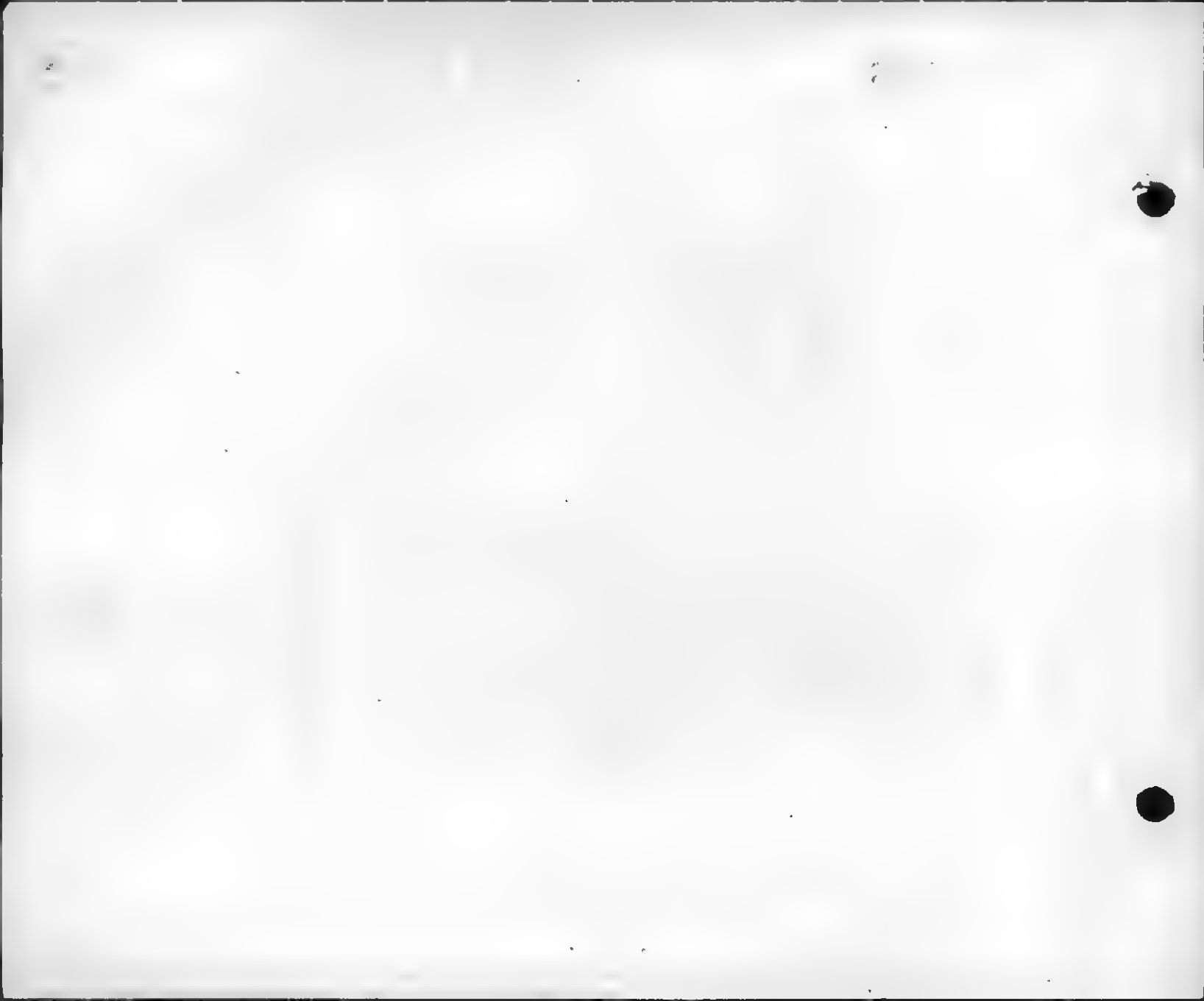
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06259

1 PLACE OF DEATH a. COUNTY BALTO. CHAPPELL HILL NURSING HOME MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Md., 21213 b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CHAPELL HILL NURSING HOME		d. STREET ADDRESS 3444 Belair Road	
3 NAME OF DECEASED (Type or print) MARIE A. FORD		4 DATE OF DEATH 9/25/67	
5 SEX F.	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12/4/04
9 AGE (In years last birthday) 62 yrs.		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY National Stationery	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Oliver Ford		14. MOTHER'S MAIDEN NAME Fannie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William Ford, Brother, above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.A. of Pneumonia & Generalized Metastases DUE TO (b) Metastases DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-1-1967 to 5-24-1967 that (I) (we) last saw the deceased alive on 5/24 1967, and that death occurred at 8:30 M, from causes and on the date stated above.			
22a. SIGNATURE Cesar Valle Cervero		22b. DATE SIGNED 5/24/67	
22c. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO		22d. ADDRESS 2624 Liberty Rd	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/27/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25a. REC'D BY REGISTRAR DATE MAY 26 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

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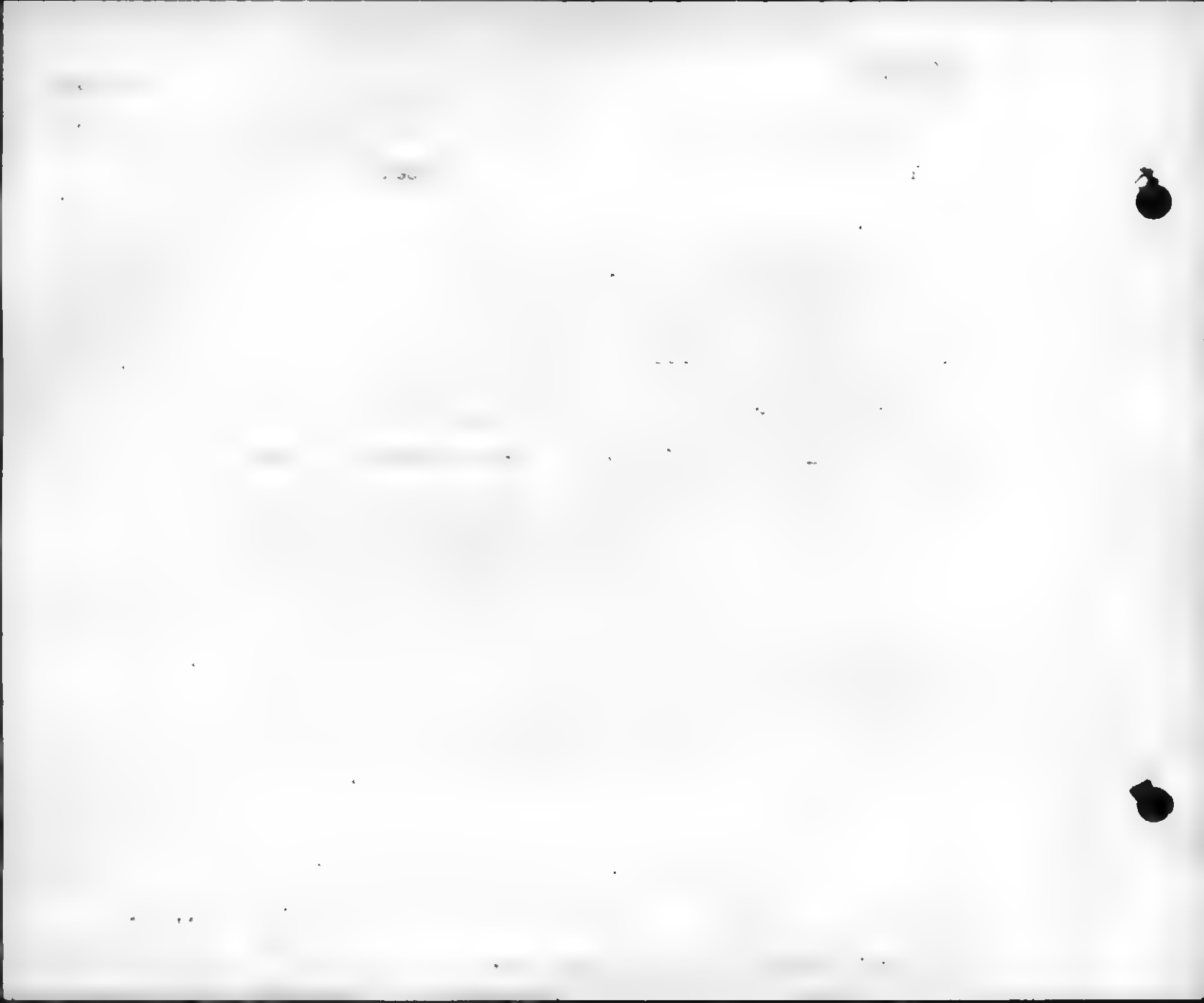
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06270

CERTIFICATE OF DEATH

06270

1 PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 701 Norris Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Romana (Mina) L. Friedel		4 DATE OF DEATH May 17 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-9-05
9 AGE (n years last birthday) 61 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Conrad Gourb		14 MOTHER'S MAIDEN NAME Matilda ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216 56 7299	
17 INFORMANT Charles Friedel		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis left coronary artery 4301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial infarction - 1 week duration DUE TO (c) Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 17 1967 to May 17 1967 , that (I) (we) last saw the deceased alive on May 17 1967 , and that death occurred at 6.45 PM from causes and on the date stated above.			
22a SIGNATURE Juana S. Cockburn		22b. DATE SIGNED 5-18-67	
22c. PHYSICIAN'S NAME (Type) Juana S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/22/67	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus	23d. LOCATION (City or Town) (County) (State) Baltimore Co., Md.
24. FUNERAL DIRECTOR Bruzdinski		25a. REGISTERED MAY 22 1967	
24. FUNERAL HOME Bruzdinski Funeral Home 1407 Eastern Ave.		25b. REGISTRAR'S SIGNATURE James Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be enclosed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

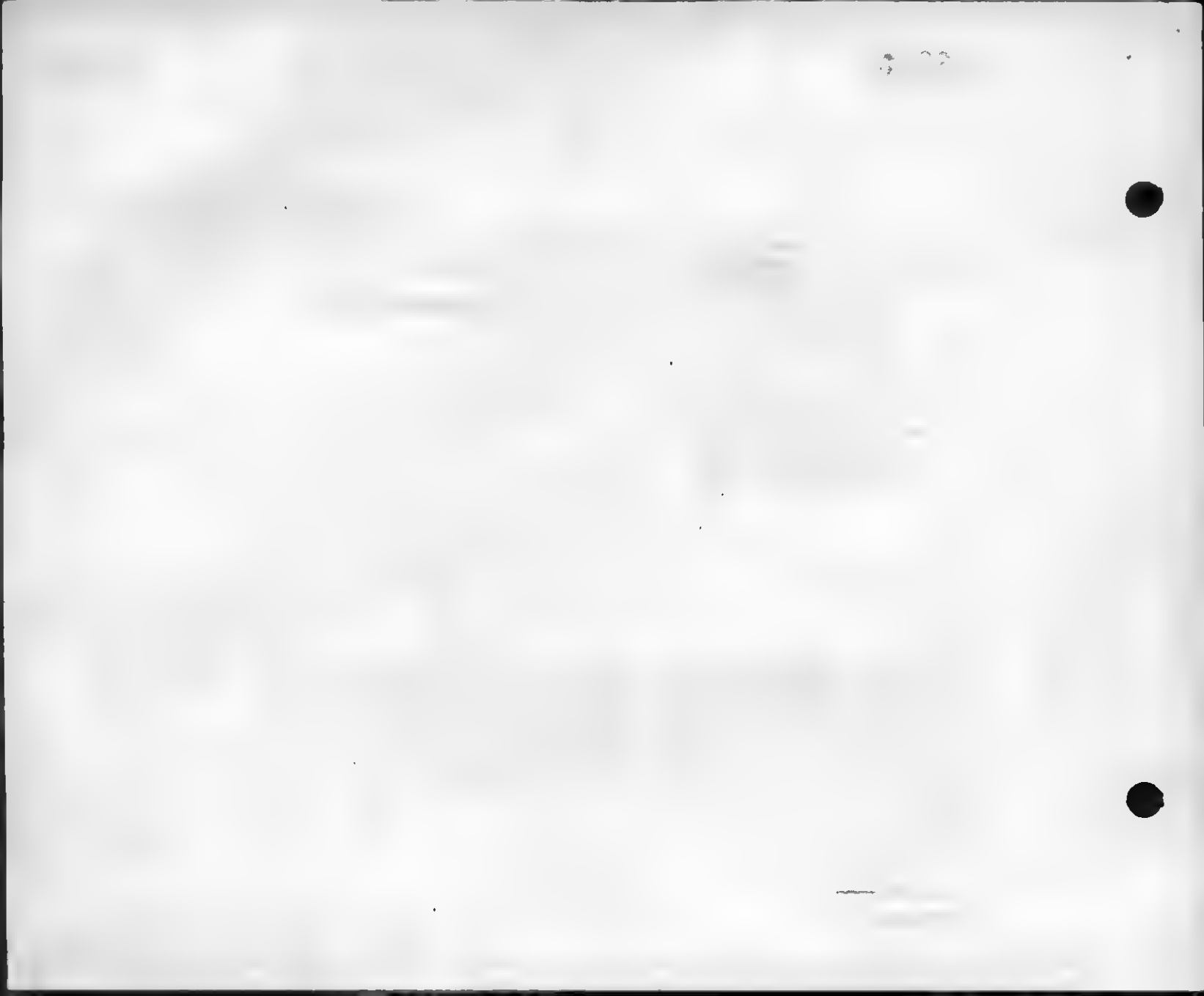
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1

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06271 CERTIFICATE OF DEATH 06261

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 21204 c. LENGTH OF STAY IN 1b 1 week d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dulaney Towson Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore, MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, MARYLAND d. STREET ADDRESS 940 OLIVESTAD ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH First Middle Last Frohsin		4. DATE OF DEATH Month Day Year May 4 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH XXXXXXXXXXXX
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		9b. KIND OF BUSINESS OR INDUSTRY MFG. REPRESENTATIVE	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY MFG. REPRESENTATIVE	
11. BIRTHPLACE (County & State, or foreign country) Atlantic City, N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Frohsin		14. MOTHER'S MAIDEN NAME Lowella Snellenberg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Dulaney Towson Nursing Home, 111 West Road		Address Baltimore, 21204	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized melanoma with brain metastasis DUE TO (b) melanoma DUE TO (c) 6 yrs CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 2 19 67 , to May 4 19 67 , that (I) (we) last saw the deceased alive on May 2 19 67 , and that death occurred at 12 PM , from the causes and on the date stated above.			
22a. SIGNATURE Jonas H. Cohen		22b. DATE SIGNED 5/4/67	
22c. PHYSICIAN'S NAME (Type) Jonas H. Cohen		22d. ADDRESS 6707 Park Heights Ave, BALTO. Md #21215	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 5/7/67	23c. NAME OF CEMETERY OR CREMATORY WOODSON PARK CREMATORY	23d. LOCATION (City, town or county) (State) FREDERICK AVENUE
24. FUNERAL DIRECTOR Samuelson Bros. 77		25a. REC'D BY REGISTRAR MAY 11 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

06272

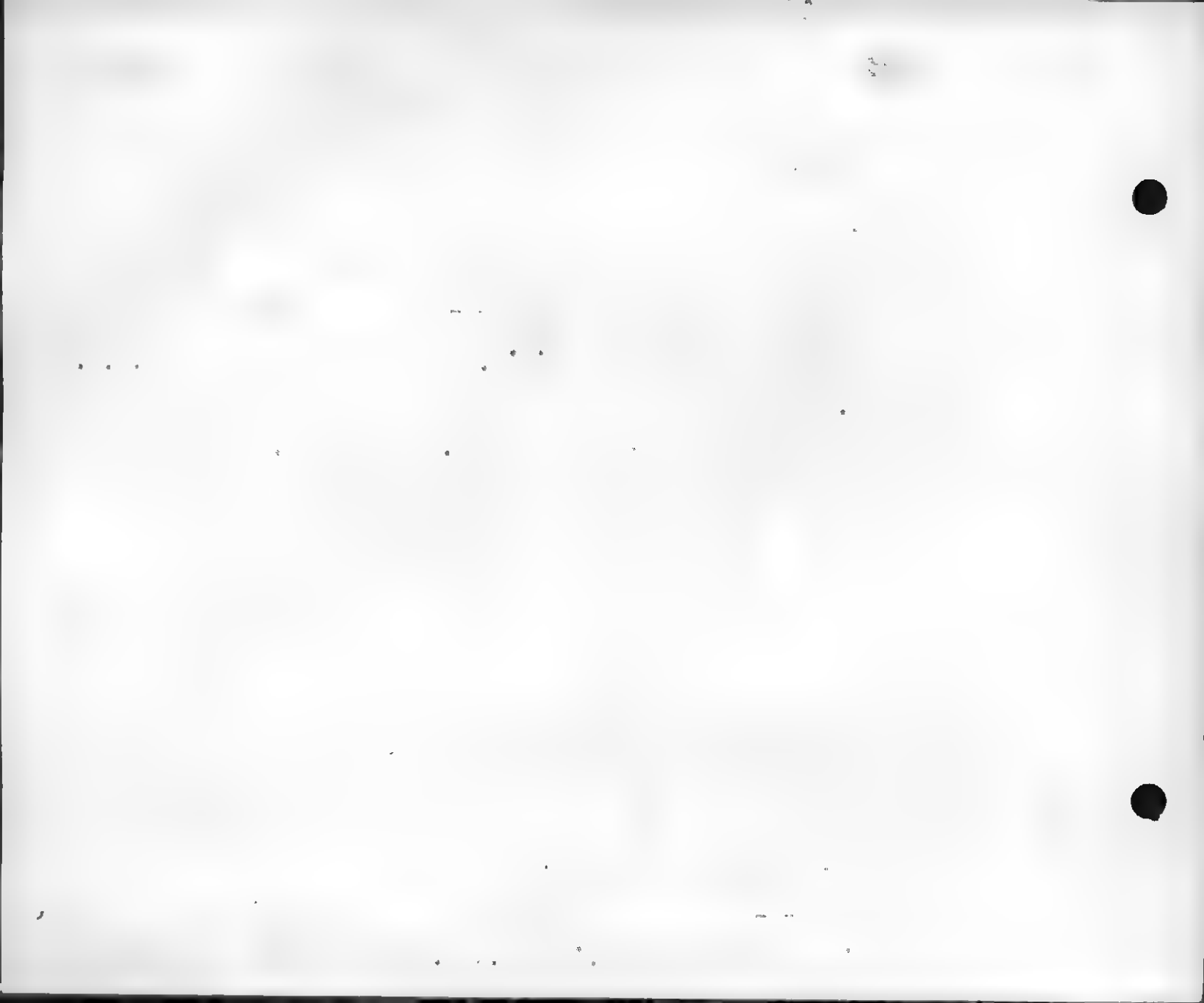
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06262

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		2 USUAL RESIDENCE (Where deceased lived if not in residence before admission) a. STATE Maryland b. COUNTY BALTIMORE	
c. LENGTH OF STAY In to Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 1007 Reister Avenue	
3 NAME OF DECEASED (Type or print) First MAX Middle R. Last FULLERTON		4 DATE OF DEATH Month May Day 4 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-8-1905
9 AGE (In years last birthday) 62 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bureau Chief	
10b. KIND OF BUSINESS OR INDUSTRY News Papers		11 BIRTHPLACE (State or foreign country) West Virginia	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME George S. Fullerton	
14 MOTHER'S MAIDEN NAME Annie Robe		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO. 233-10-6544		17 INFORMANT Address Mrs. Virginia R. Fullerton Same	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 834.4 Cerebrocranial injuries DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WA. AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Fell while getting out of car at home	
20c. TIME OF INJURY Month, Day Year 11:40 p.m. 5 - 3 1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) curb - at home	20f. (City or town) (County) (State) Baltimore Md
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		22. DATE SIGNED May 5, 1967	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MED. CA. EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 5-8-1967	23c. NAME OF CEMETERY OR CREMATORY Greenmount	23d. LOCATION (City or town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR Henry W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR MAY 10 1967	
ADDRESS 21212 4905 York Rd. Balto., Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be read as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

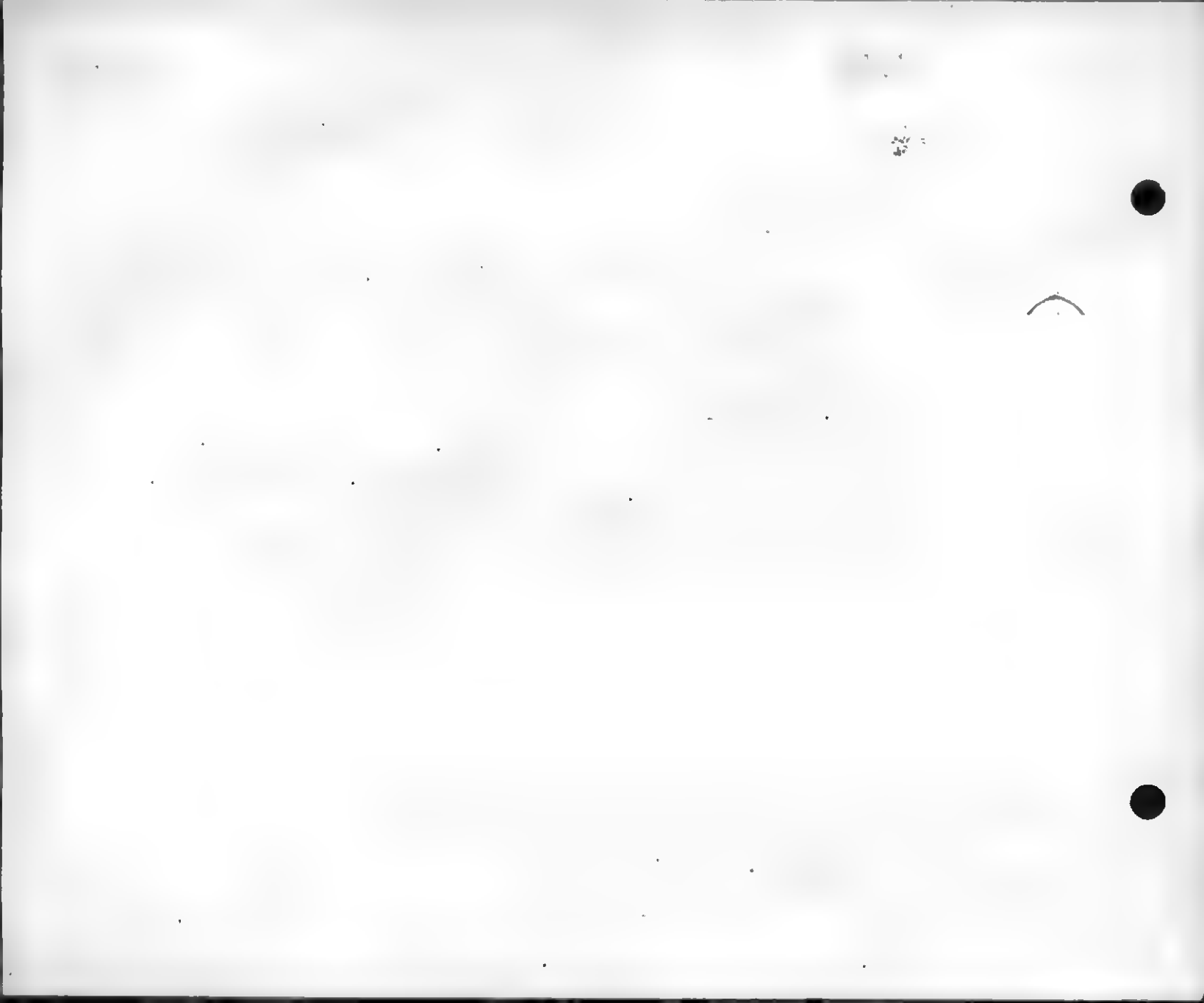
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06273

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06263

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay c. LENGTH OF STAY IN b 21227 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1544 Rolling Rd.			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1544 South Rolling Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) Harry Gorsuch Gallagher, Sr.			4 DATE OF DEATH Month May Day 26 Year 1967		
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/21/87 82	9 AGE (In years (at birthday)) 85 yrs	IF UNDER 1 YEAR Months 26 Days 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Retired	11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME Charles M. Gallagher			14 MOTHER'S MAIDEN NAME Anna Handly		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	17. INFORMANT Harry G. Gallagher, Jr. 975 River Blvd., Suffield, Conn.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Carcinoma - Colon DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ASCVD 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James N. Frederick, M.D. EXAMINER'S NAME (Type)			22. DATE SIGNED 5/26/67 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/29/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24 FUNERAL DIRECTOR HOWARD H. HUBBARD			25a. REC'D BY REGISTRAR MAY 29 1967 25b. REGISTRAR'S SIGNATURE Charles Judge		



06274

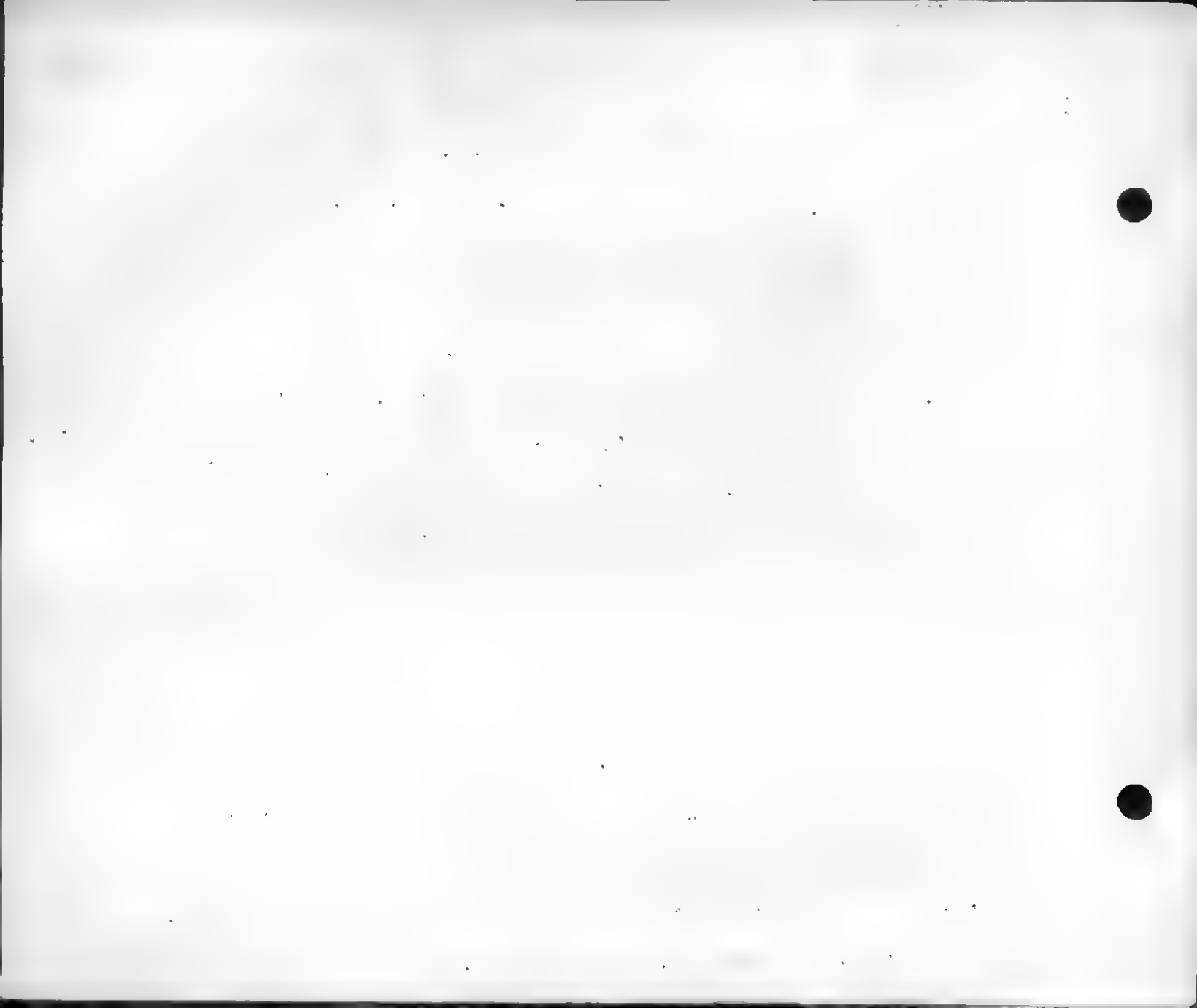
CERTIFICATE OF DEATH

Reg. Dist. No. 56254

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b Eight Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box-409 B. Rt. 16		e. STREET ADDRESS Box-409 B. Rt. 16	
3. NAME OF DECEASED (Type or print) First Olive Middle Beatrice Last Garrett		4. DATE OF DEATH Month May Day 9 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 22, 1892
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months 8 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Penn.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. Nelson Palmer		14. MOTHER'S MAIDEN NAME Mary O. Wilhelm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 213-42-3807A	
17. INFORMANT Mr. Charles R. Garrett		Address 29 Carlenda Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC INTRABR. CARCINOMA ASCITES DUE TO INDOLEURABLE CARCINOMA Ovary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) INDOLEURABLE CARCINOMA Ovary (c) INDOLEURABLE CARCINOMA Ovary		INTERVAL BETWEEN ONSET AND DEATH 8 MRS. 1 YR.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/20 , 19 66 , to 5/9 , 19 67 , that I last saw the deceased alive on 5/8 , 19 67 , and that death occurred at 4:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert Healy		ADDRESS (Street, city or town, state) 3350 Wilkins Avenue	
PHYSICIAN'S NAME (Type) Robert Healy		DATE SIGNED 5/10/67	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/10/67	22c. NAME OF CEMETERY OR CREMATORY New Freedom Cemetery	22d. LOCATION (City, town, or county) (State) New Freedom Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Henry Sander & Sons Inc. Baltimore Md.		24. REG. BY REGISTRAR MAY 12 1967	
ADDRESS Henry Sander & Sons Inc. Baltimore Md.		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the funeral director, and completely filled in by the funeral director. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

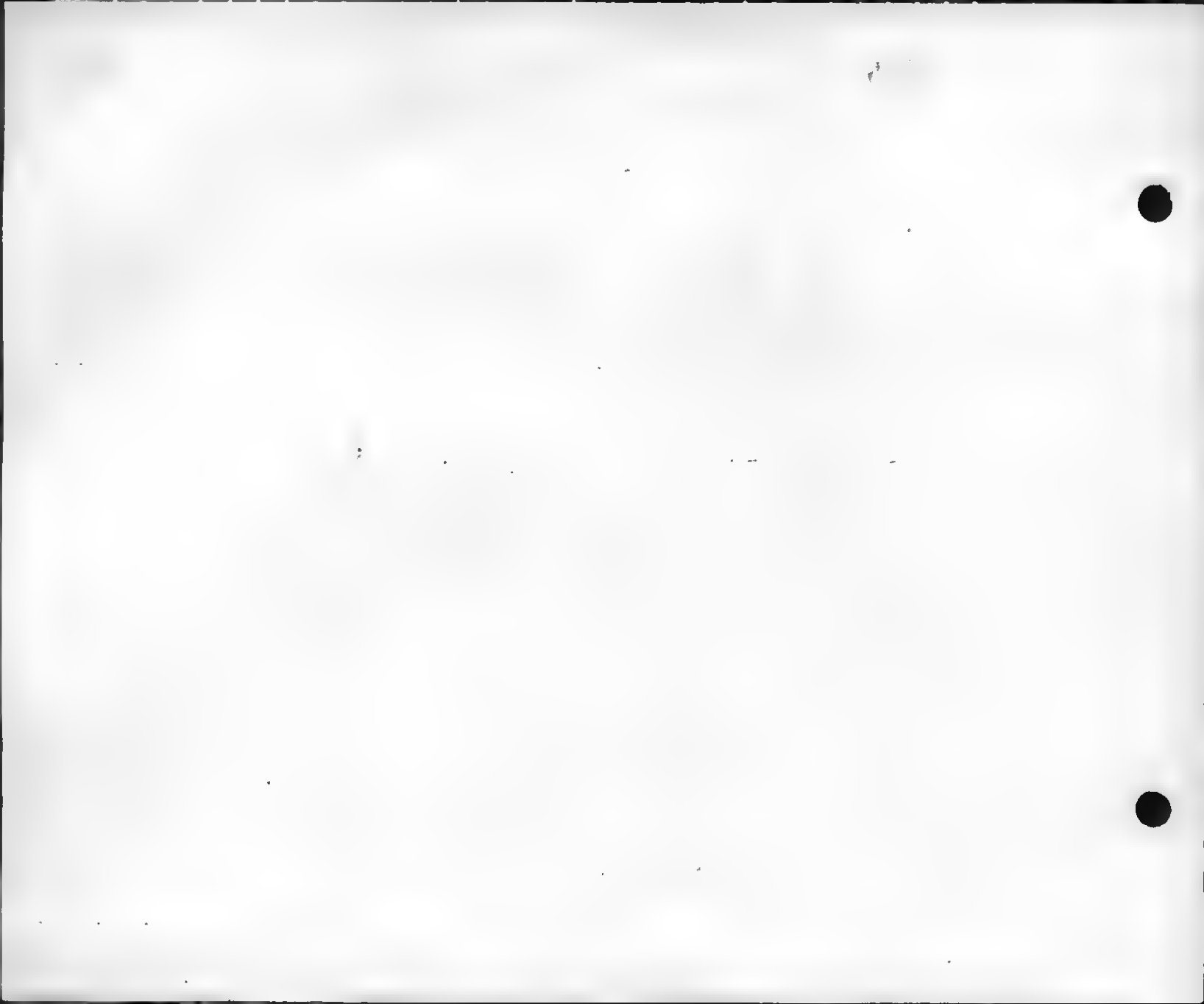
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06275

CERTIFICATE OF DEATH

00285

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if instit an Residence before adm ssion) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN TB 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospita., give street address) St. Josephs Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ROBERT Middle CORNELIUS Last GAY		4 DATE OF DEATH Month May Day 20 Year 1967	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH May 22 1905
9. AGE (In years last birthday) 61 yrs		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) technician		10b. KIND OF BUSINESS OR INDUSTRY T.V.	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME William Henry Gay		14 MOTHER'S MAIDEN NAME Nellie Dutrow	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 217-09-8492	
17 INFORMANT Marie E. Gay, S Warren Lodge Ct. 21030		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pancreatitis. DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchiectasis, right lung.		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 20, 1967 to May 20, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 20, 1967 , and that death occurred at 5:25 P.M. from causes and on the date stated above.			
22a. SIGNATURE Manuel S. Cockburn, M.D.		22b. DATE SIGNED 5/21/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 7620 York Road, Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF May 24, 1967	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Parkville, Balto. Co., Md.
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204		25a. REC'D BY REGISTRAR MAY 23 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

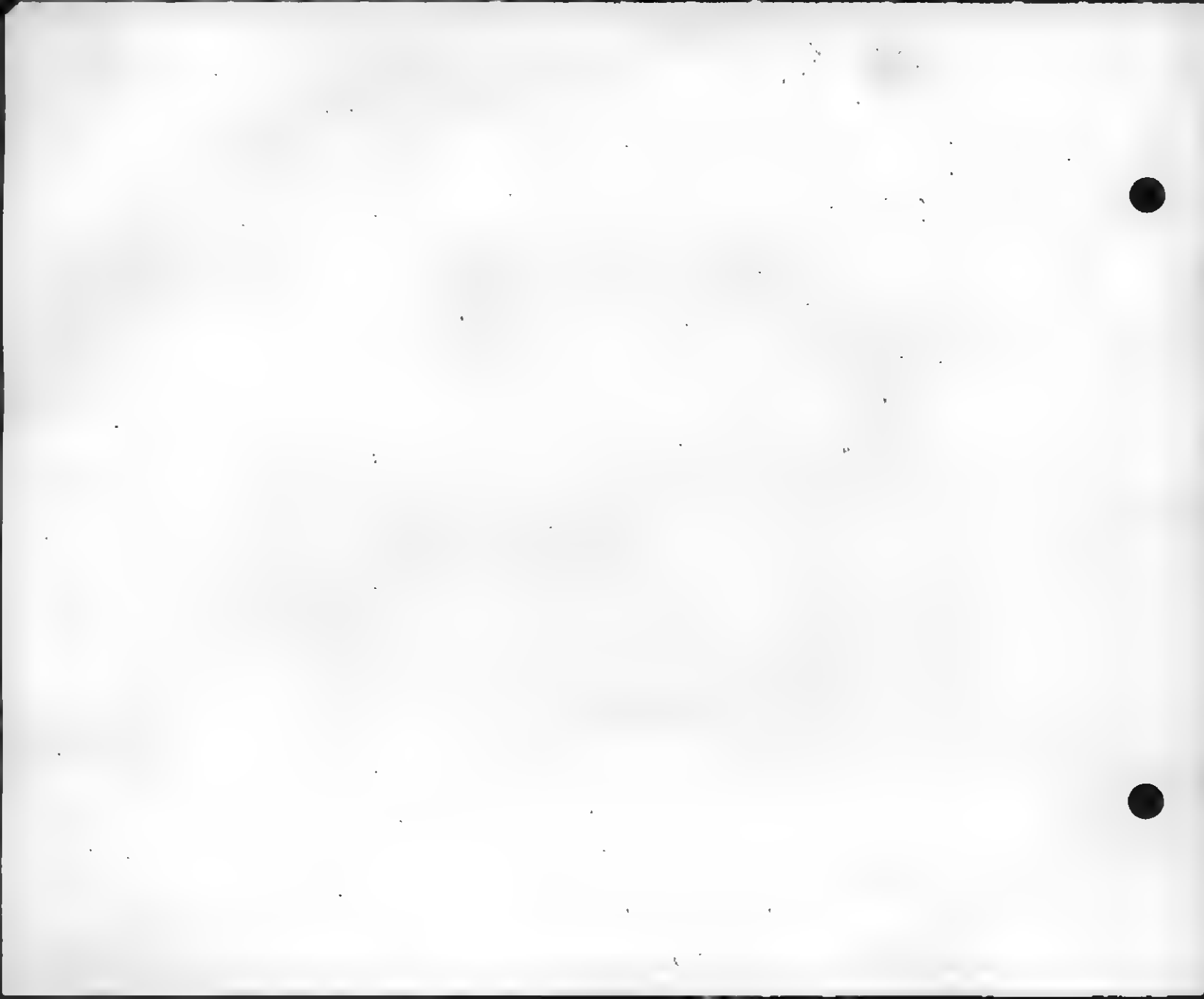


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>29 Normal Terrace</u>		d. STREET ADDRESS <u>29 Normal Terrace</u>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Donovan</u> Last <u>German</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 11, 1895</u>
9. AGE (in years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Owen J. Donovan</u>		14. MOTHER'S MAIDEN NAME <u>Mary L. Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANOXIA</u> DUE TO (b) <u>BILATERAL PLEURAL EFFUSION</u> DUE TO (c) <u>CARCINOMATOSIS (ADENOCARCINOMA OF BREAST)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>1 YEAR</u> <u>10 YEARS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>AUG 28</u> , 19 <u>62</u> to <u>MAY 5</u> , 19 <u>67</u> that (I) was last saw the deceased alive on <u>MAY 5</u> 19 <u>67</u> , and that death occurred at <u>4:55</u> P.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Donald L. Somerville</u>		22b. DATE SIGNED <u>5/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DONALD L. SOMERVILLE, MD</u>		22d. ADDRESS <u>25 W. PA. AVE. TOWSON, MD 21204</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>May 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Maria Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Towson, Maryland</u>
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25. REC'D BY REGISTRAR <u>MAY 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06277

Item #8 Film #G384 6/5/67

CERTIFICATE OF DEATH

06267

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Baltimore ✓	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor Nursing Home		d STREET ADDRESS 1918 East 31st. Street	
3. NAME OF DECEASED (Type or print) Anita First W. Middle Gibson Last		4. DATE OF DEATH Month 5 Day 26 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6/22/1881
9 AGE (In years last birthday) 74 yrs		10 IF UNDER 1 YEAR Months 26 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never worked		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Deal Island, Md.		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Lazarus Wilson		14 MOTHER'S MAIDEN NAME Annie Price	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17. INFORMANT Mrs. Laiverence Adams		6002 Elserod Ave. Baltimore, Md. 14	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute heart failure 4500 DUE TO (b) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 9/5 , 19 65 , to 5/26 , 19 67 that (I) (we) last saw the deceased alive on 5/23 , 19 67 , and that death occurred at 10:30 M, from causes and on the date stated above.			
22a. SIGNATURE William F. Fritz		22b. DATE SIGNED 5/27/67	
22c. PHYSICIAN'S NAME (Type) WILLIAM F. FRITZ, M.D.		22d. ADDRESS 2 WEST UNIVERSITY PKWAY, 21218	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/29/1967	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR Wm. F. Tinkner		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 31 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06278 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE c. LENGTH OF STAY IN 1b 18 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTO MED. CENTER						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lansdowne d. STREET ADDRESS 413 4th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) SAMUEL CARL GILES			4. DATE OF DEATH 5 / 1 / 1967			5. SEX MALE			6. COLOR OR RACE CAU.		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 9/17/90			9. AGE (in years last birthday) 76 yrs.			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Builder				10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel				11. BIRTHPLACE (County & State, or foreign country) Beth., Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME GEORGE GILES				14. MOTHER'S MAIDEN NAME SHOCKER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) --				16. SOCIAL SECURITY NO. 213-09-2304A				17. INFORMANT PR. HISTORY Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure DUE TO (b) massive pulmonary hemorrhage DUE TO (c) Carcinoma of lung PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 14, 1967 to May 1, 1967 that (I) (we) last saw the deceased alive on May 1, 1967 and that death occurred at 2:45 AM from the causes and on the date stated above.											
22a. SIGNATURE Robert W. Smith						22b. DATE SIGNED 5-1-67		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/3/67		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d. LOCATION (City, town or county) (State) Dorsey, Md.			
24. FUNERAL DIRECTOR JOHN F. DENNY, Inc.						25a. REC'D BY REGISTRAR 7 Charles Judge		25b. REGISTRAR'S SIGNATURE		DATE MAY 3 1967	
ADDRESS 715 Light St.											

1. The first part of the document
describes the general situation
of the country and the
state of the economy.
It also mentions the
importance of the
agriculture and the
industry.

2. The second part of the document
describes the political situation
of the country and the
state of the government.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06279

CERTIFICATE OF DEATH

06269

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, Baltimore Md. 21204		d. STREET ADDRESS 8210 Pleasant Plains Rd. 21204	
3. NAME OF DECEASED (Type or print) First CHARLES Middle L Last GLODEK		4. DATE OF DEATH Month MAY Day 14 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-24-18
9. AGE (in years lost birthday) 48 yrs		10. IF UNDER 1 YEAR Months Days	10. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steelworker		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Valentine Gledek		14. MOTHER'S MAIDEN NAME Marcella Jakoubowski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 212-10-2587	
17. INFORMANT Wife - Lillian - same		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY 593 X IMMEDIATE CAUSE (a) Uremia DUE TO (b) Chronic renal failure DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-4 , 19 67 , to 5-14 , 19 67 , that (I) (we) last saw the deceased alive on 5-14 , 19 67 , and that death occurred at 9:40 A.M. from causes and on the date stated above			
22a. SIGNATURE <i>Efraim L. Reyes</i>		22b. DATE SIGNED 5-14-67	
22c. PHYSICIAN'S NAME (Type) Efraim L. Reyes, M.D.		22d. ADDRESS 7620 York Road, Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-17-67	23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland.
24. FUNERAL DIRECTOR Johnson Funeral Home.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE MAY 18 1967	
25c. ADDRESS 8521 Loch Raven Blvd. Balto. Md.			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

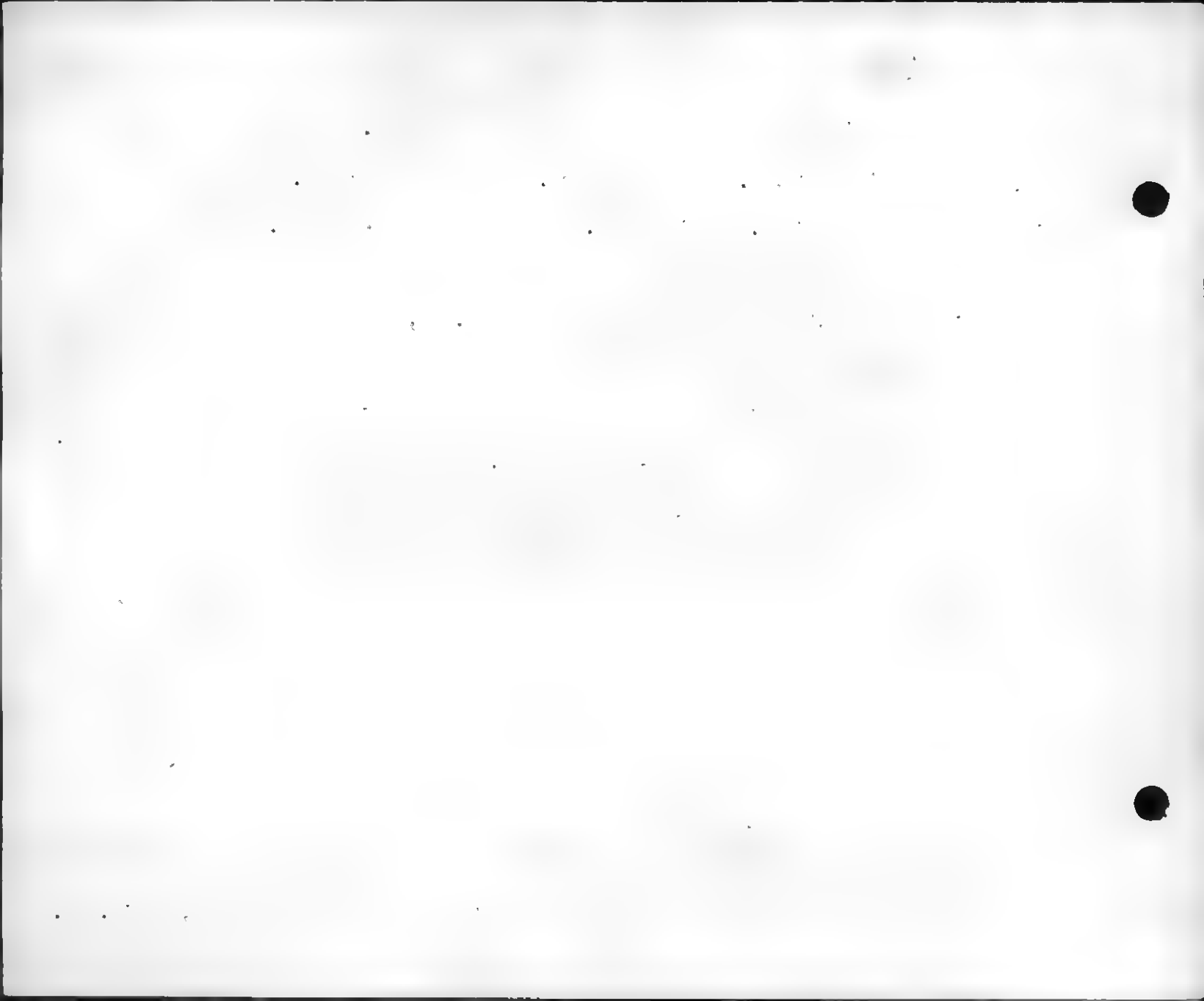
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06280

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06270

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 15, Md.</u>		c. LENGTH OF STAY IN 1b <u>12 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4150 Fallstaff Rd., Baltimore, Md.</u>		e. STREET ADDRESS <u>4150 Fallstaff Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Francesco</u> <u>Glorioso</u>		4 DATE OF DEATH <u>May 12,</u> 19 <u>67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 29, 1891</u>
9 AGE (In years lost birthday) <u>15</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11c. BIRTHPLACE (State or foreign country) <u>Italy</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13 FATHER'S NAME <u>Rosario Glorioso</u>		14 MOTHER'S MAIDEN NAME <u>Rosario Saia</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16 SOCIAL SECURITY NO <u>212-36-0069</u>	
17 INFORMANT <u>Mr. Joseph Glorioso, 117 Chestnut Hill Lane</u>		18 ADDRESS <u>Reisterstown, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary artery Disease</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <u>None</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, off ca bldg, etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D.D. Caples</u> M.D.		22. DATE SIGNED <u>5/15/67</u>	
EXAMINER'S NAME (Type) <u>D.D. CAPLES</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <u> </u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 16, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Pikesville, Baltio., Md.</u>
24. FUNERAL DIRECTOR <u>Frank H. Newell, Pikesville, Md.</u>		25. REC'D BY REGISTRAR <u>5 MAY 17 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06281 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN 1b <u>5 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>320 S. Robinson ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Helen E. Goepfert</u>						4. DATE OF DEATH <u>5 7 1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-27-08</u>		9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (County & State, or foreign country) <u>Unknown Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Luczkowski</u>						14. MOTHER'S MAIDEN NAME <u>Groslof</u> <u>Frances Groslof</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Patient's Chart</u> Address _____					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Atherosclerotic Cardiovascular disease</u> DUE TO (c) <u>with concomitant pernicious anemia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____										INTERVAL BETWEEN ONSET AND DEATH <u>15 mins</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>5-7 1967</u> to <u>5-7 1967</u> , that (I) (we) last saw the deceased alive on <u>5-7 1967</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>V.R. Batoyon, M.D.</u>						ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>VIVIAN R. BATOYON</u>						22d. ADDRESS _____					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, XXXXXX (State)					
<u>Burial</u>		<u>5/11/67</u>		<u>Holy Redeemer</u>		<u>Baltimore, Maryland</u>					
24. FUNERAL DIRECTOR <u>M.F. SADOWSKI & SONS, 1808 EASTERN AVE</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
						DATE <u>MAY 10 1967</u>					

2.



1. The first part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Army, dated October 1, 1900. The letter is addressed to the Secretary of the Department of the Army, and is signed by the Secretary of the Department of the Interior.

2. The second part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Army, dated October 1, 1900. The letter is addressed to the Secretary of the Department of the Army, and is signed by the Secretary of the Department of the Interior.

3. The third part of the document is a letter from the Secretary of the Department of the Interior to the Secretary of the Department of the Army, dated October 1, 1900. The letter is addressed to the Secretary of the Department of the Army, and is signed by the Secretary of the Department of the Interior.



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VR A15 (4)
20 M 1/66

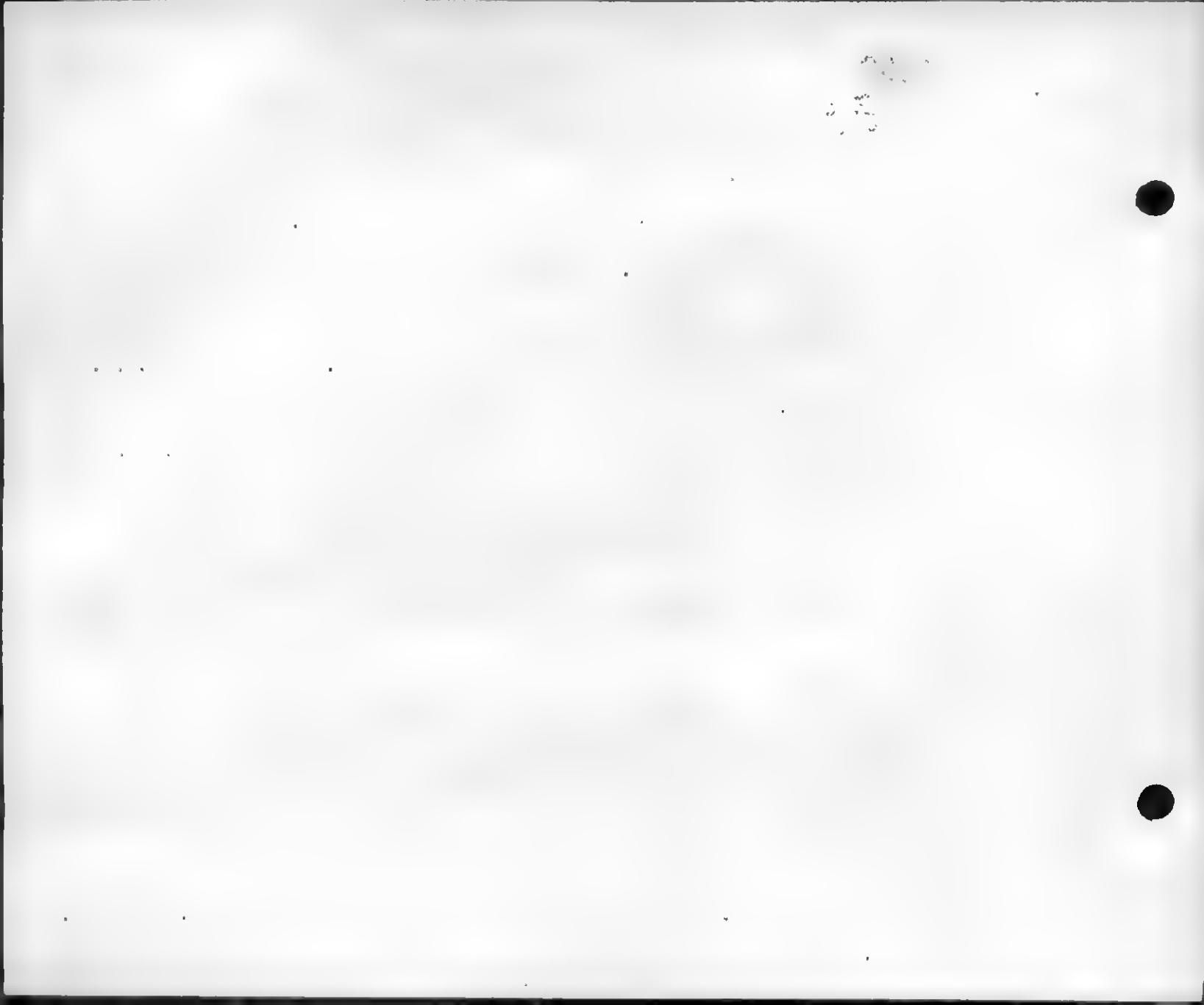
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06282

CERTIFICATE OF DEATH

1967

1. PLACE OF DEATH a. COUNTY <u>Baltimore County, Md.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Baltimore, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
c. LENGTH OF STAY in lb <u>2 days</u>				d. STREET ADDRESS <u>60 Southgate Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jeanette</u> Middle <u>C.</u> Last <u>Goodman</u>				4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/6/87</u>	9. AGE (In years last birthday) <u>80</u> yrs	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Louis Isaacson I soc Sohn</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Forman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>213-34-2783</u>			16. SOCIAL SECURITY NO <u>213-34-2783</u>		17. INFORMANT <u>Miss Hilda Goodman</u>		Address <u>Annapolis, Md.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) - PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest failure 2°</u> DUE TO <u>Ventricular tachycardia & Libullation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Severe Arteriosclerosis Heart Disease</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>YEARS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-11</u> , 19 <u>67</u> , to <u>5-13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-13</u> , 19 <u>67</u> , and that death occurred at <u>7:30</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Angela D. Toppan</u>				22b. DATE SIGNED <u>5-13-67</u>		22c. PHYSICIAN'S NAME (Type) <u>ANGELA D. TOPPAN</u>	
22d. ADDRESS <u>BETH</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 15, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Kneseth Israel</u>		23d. LOCATION (City or Town) (County) (State) <u>Annapolis, Md. Anne Arundel, Md.</u>	
24. FUNERAL DIRECTOR <u>Beverley E. Hopping, Hopping Funeral Home</u>				25a. RECEIVED BY REGISTRAR <u>MAY 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	
25c. ADDRESS <u>Annapolis, Md.</u>				25d. DATE <u>MAY 17 1967</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

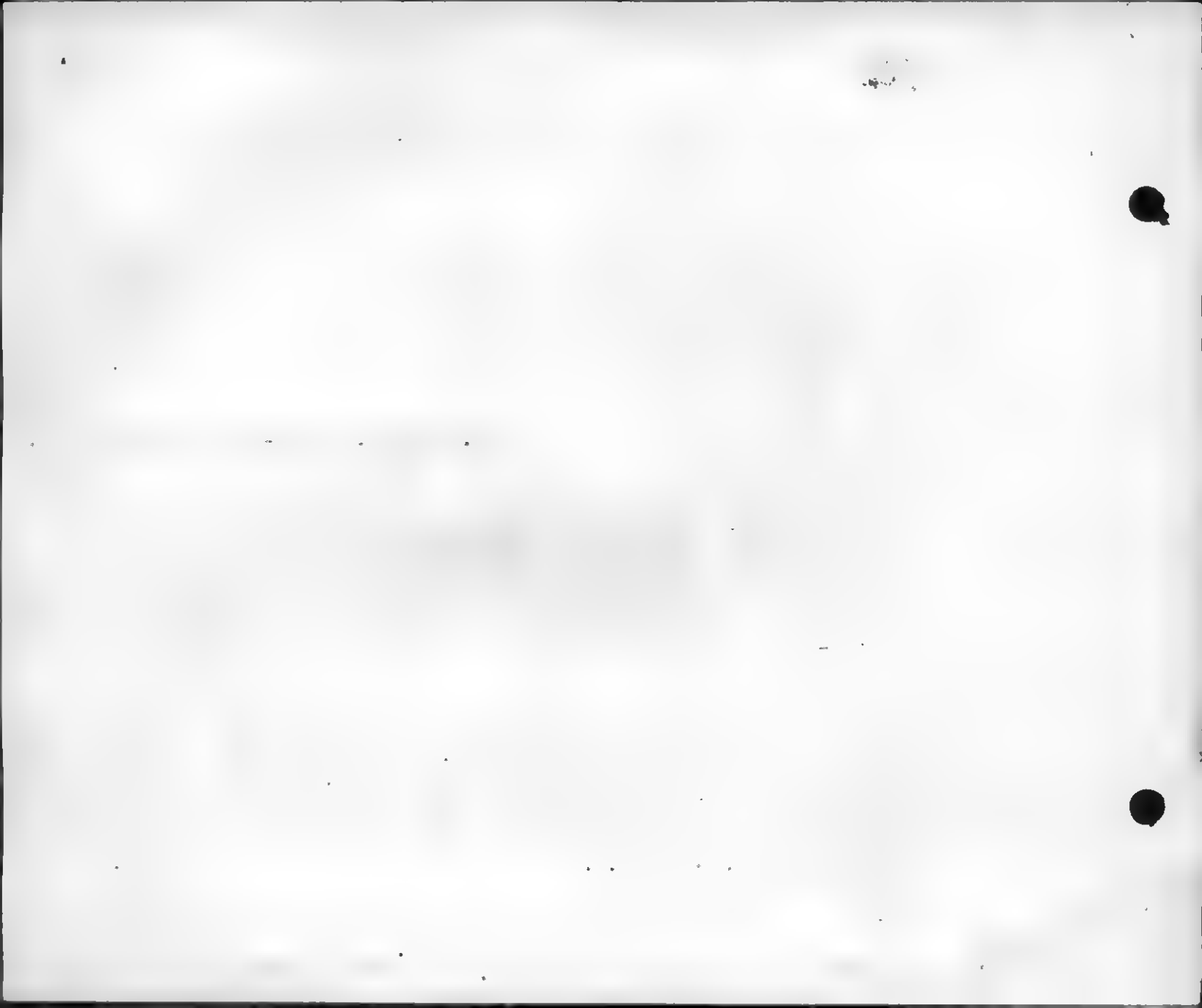
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06283

CERTIFICATE OF DEATH

06283

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, first location. Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 77 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				e. STREET ADDRESS 7117 Chamberlain Road			
3. NAME OF DECEASED (Type or print) First Middle Last RALPH MICHAEL GOONER				4. DATE OF DEATH Month Day Year May 13 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/25		9. AGE (in years last birthday) 42 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager			10b. KIND OF BUSINESS OR INDUSTRY Fleet Truck Motors		11. BIRTHPLACE (County & State, or foreign country) Milford, Dela.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Willis Gooner				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW1		16. SOCIAL SECURITY NO 221 12 47 78		17. INFORMANT Mrs. Ralph M. Gooner-7117 Chamberlain Rd. Clinical Rcds, VA Hospital, Fort Howard, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA (b) MULTIPLE ABSCESSSES, CHRONIC, LEFT PLEURAL CAVITY, LEFT LOWER THORACIC WALL, PELVIC CA VITY (c) METASTATIC ADENOCARCINOMA, LIVER AND MESENTERIC LYMPH NODES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Entero-Cutaneous Fistula							INTERVAL BETWEEN ONSET AND DEATH Weeks Months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour "a.m." "p.m." 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from Feb. 25 , 19 67 , to May 13 , 19 67 that (b) (we) last saw the deceased alive on May 13 , 19 67 , and that death occurred at 6 A. M., from causes and on the date stated above.							
22a. SIGNATURE Alfonso A. Lopez, M.D.				22b. DATE SIGNED 5/13/67		22c. PHYSICIAN'S NAME (Type) ALFONSO A. LOPEZ, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/16/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR WITZKE FUNERAL HOME				25a. REC'D BY REGISTRAR DATE MAY 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

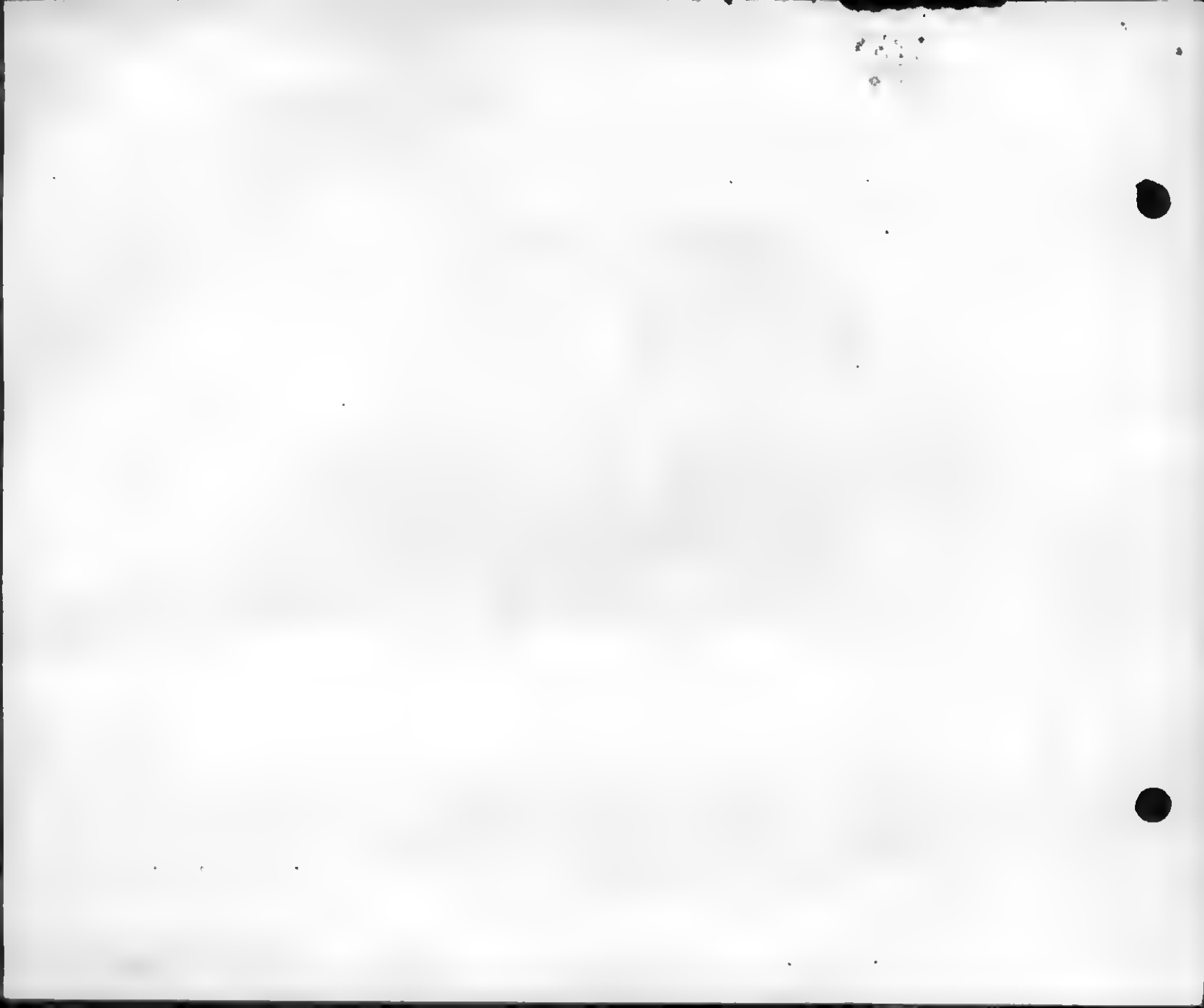
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06284

CERTIFICATE OF DEATH

06274

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b TOWSON			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital				d. STREET ADDRESS 2501 Hillford Drive			
3. NAME OF DECEASED (Type or print) First Middle Last Edwin Rayne GOWLAND				4. DATE OF DEATH Month Day Year May 25 19 67			
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 4, 1894	9 AGE (in years last birthday) 72 y/s	10 IF UNDER 1 YEAR Months Ooys Hours Min		11 IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist			10b. KIND OF BUSINESS OR INDUSTRY CROWN C+S		11. BIRTHPLACE (County & State, or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME Wm. Frederick Gowland				14. MOTHER'S MAIDEN NAME M. A. Feistil			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give unit and dates of service) Yes WW II			16. SOCIAL SECURITY NO. 188-05-6564		17. INFORMANT Family Records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema secondary to anemic 2424 DUE TO Heart Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to hypoplasia of bone marrow. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 22 , 1967, to May 25 , 1967, that (I) (we) last saw the deceased alive on May 25 , 1967, and that death occurred at 1:30 M. from causes and on the date stated above							
22a. SIGNATURE Lawrence F. Misanik, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS 7620 York Rd. Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5-26-1967		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cem		23d. LOCATION (City or town) (County) (State) York Penn	
24. FUNERAL DIRECTOR C. F. Evans & Son				25a. REC'D BY REGISTRAR 8802 Harford Rd		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36285

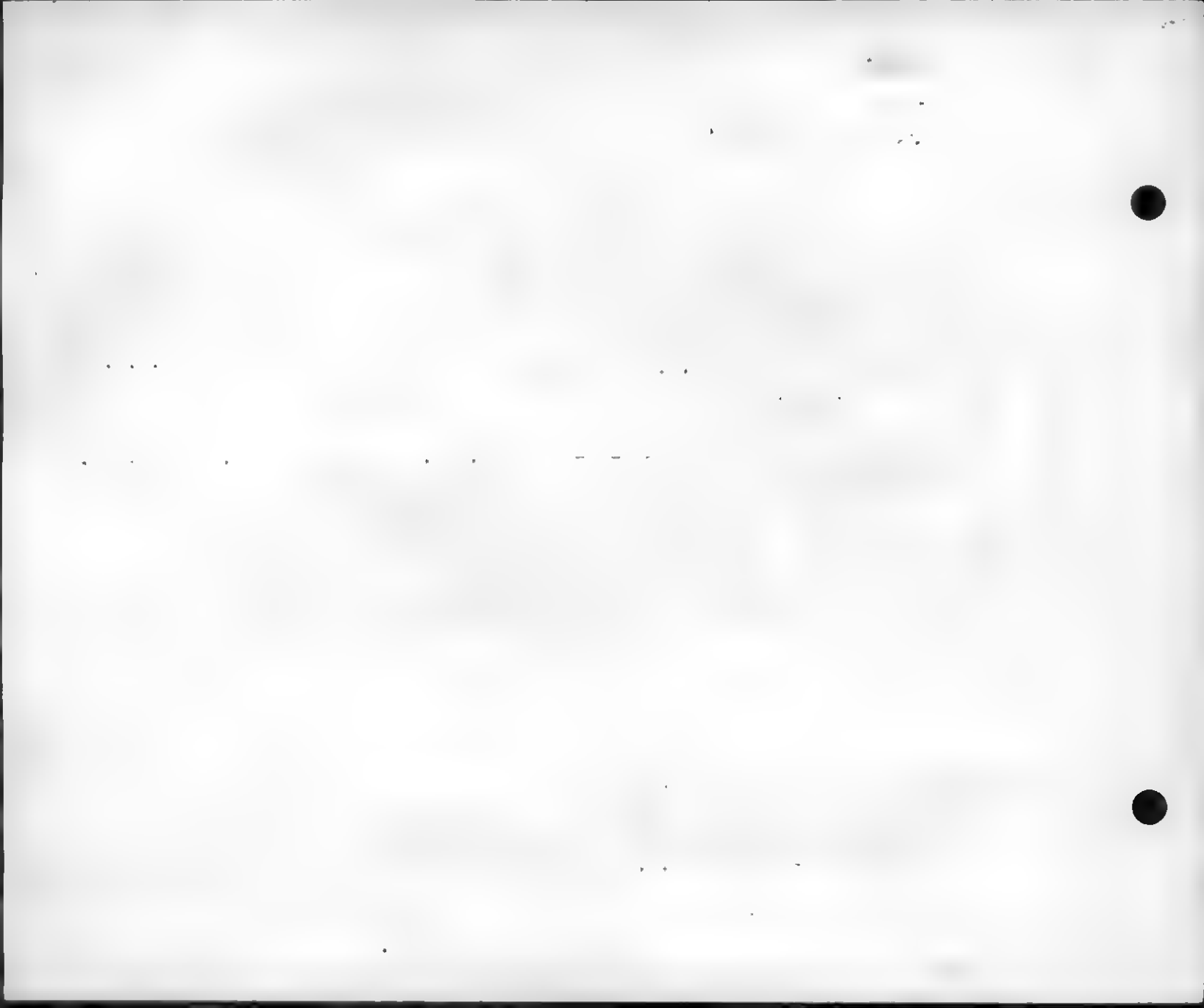
CERTIFICATE OF DEATH

00275

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please replace carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c LENGTH OF STAY IN TB 19 Days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e STREET ADDRESS 4409 Fernhill Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last VICTOR VINCENT GRELLI		4 DATE OF DEATH Month Day Year MAY 27 19 67	
5. SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/18
9 AGE (In years last birthday) yrs 48		10 IF UNDER 1 YEAR Months Days Hours Min. 48 48	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY U.S. Coast Guard	
11 BIRTHPLACE (County & State or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vincent Grelli		14. MOTHER'S MAIDEN NAME Philemonia	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16 SOCIAL SECURITY NO. 213-14-82-04	
17 INFORMANT Clin. Rec. VA HOSPITAL, Ft. Howard, Md.		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN TUMOR LEFT FRONTAL LOBE 231X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from May 8, 1967 to May 27, 1967 , that (we) last saw the deceased alive on May 27, 1967 , and that death occurred at 7:00 AM from causes and on the date stated above			
22a. SIGNATURE ZUI-SUN TAO, M.D.		22b. DATE SIGNED 5/27/67	
22c. PHYSICIAN'S NAME (Type) ZUI-SUN TAO, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 5-31-67	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City or town) (County) (State) Baltimore, Maryland	
23e. ADDRESS 4600 Liberty Hgts Ave		23f. REC'D BY REGISTRAR MAY 31 1967	
23g. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06286

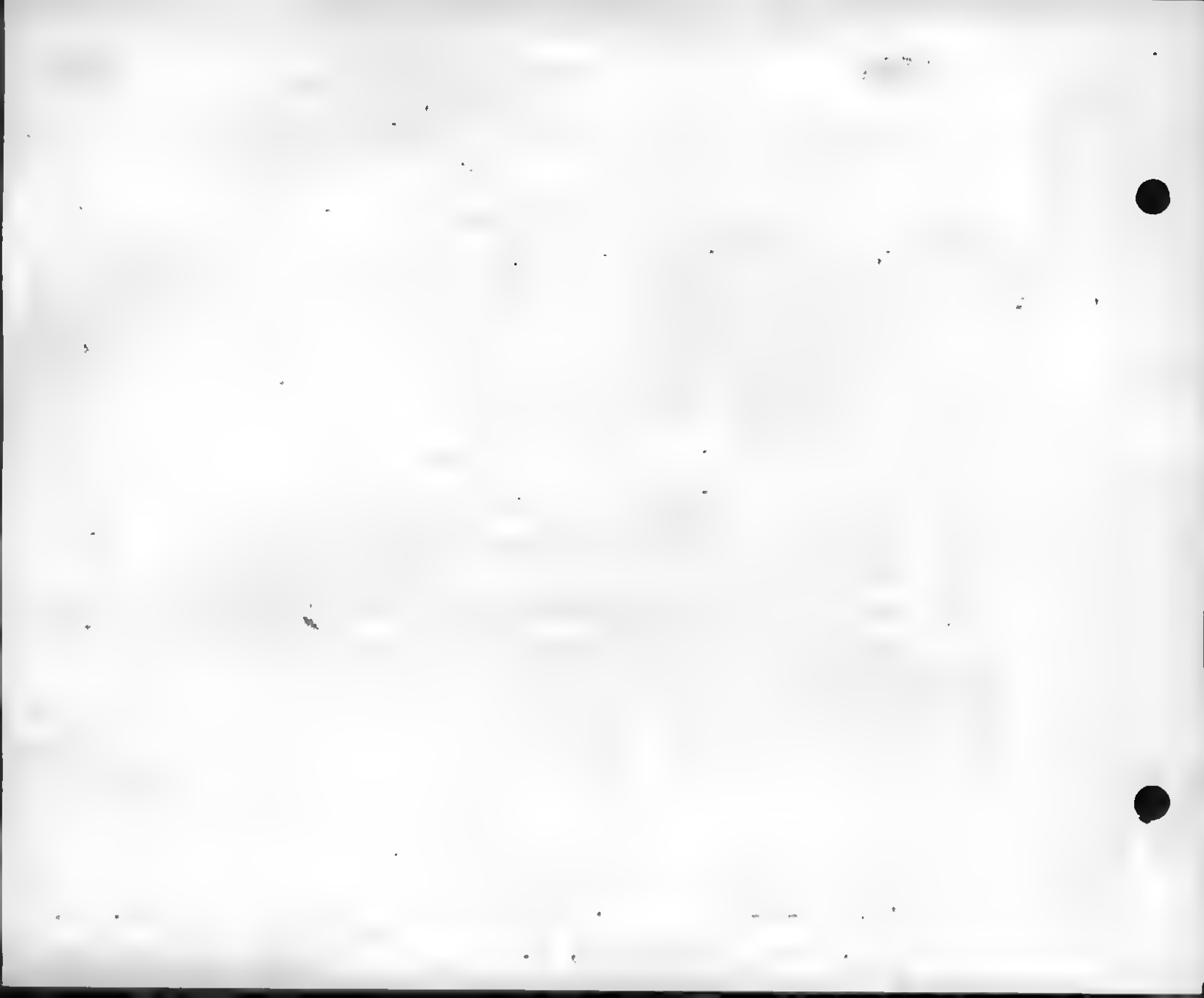
CERTIFICATE OF DEATH

06276

1 PLACE OF DEATH a COUNTY Baltimore County MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b. COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		e STREET ADDRESS Rt 1 Box 27	
3 NAME OF DECEASED (Type or print) THOMAS CLIFTON GRIMES		4. DATE OF DEATH Month 5 Day 10 Year 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/20/1892
9. AGE (n years last birthday) yrs 74		10. IF UNDER 1 YEAR Months 7 Days 15	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b KIND OF BUSINESS OR INDUSTRY Farm	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME WILLIAM GRIMES		14. MOTHER'S M maiden NAME DELLA EYLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-10-0979	
17. INFORMANT Records, Mount Wilson State Hospital		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days 15 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic obstructive airway disease (Emphysema)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5.1. 1967 , to 5.10. 1967 , that (I) (we) last saw the deceased alive on 5.12. 1967 , and that death occurred at 5:40 AM , from causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED 5.10.1967	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-13-67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City or Town) (County) (State) Frederick, Fred. Md.	
24 FUNERAL DIRECTOR Francis H. Barber		25a. REG. BY REGISTRAR MAY 12 1967	
ADDRESS Laytonville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06287

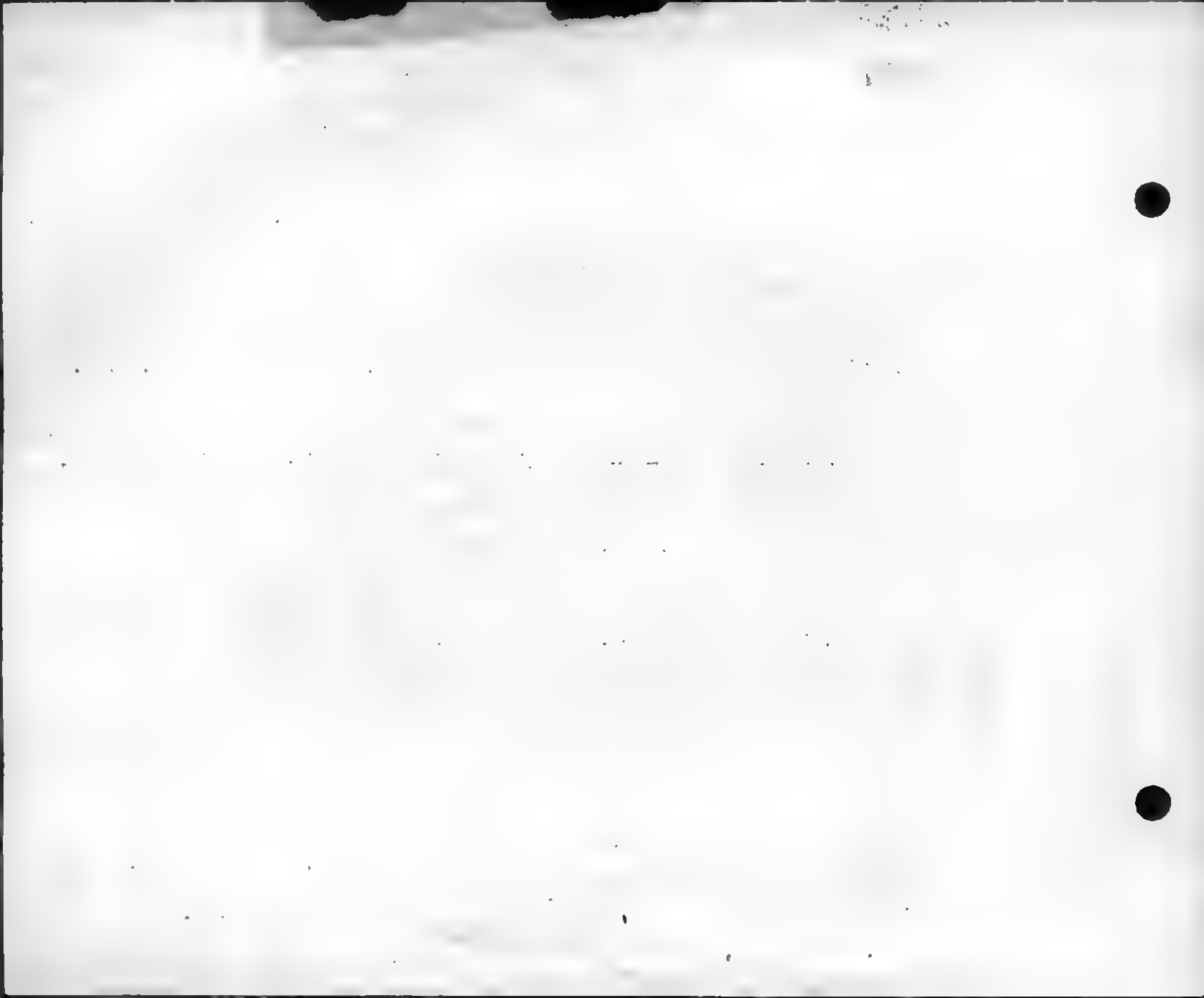
CERTIFICATE OF DEATH

06277

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b Life		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland #21231 b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St Joseph Hospital		d. STREET ADDRESS 1807 Aliceanna St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Constance Middle A. Last Gruszczynski		4. DATE OF DEATH Month 5 Day 16 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/1897
9. AGE (In years last birthday) 70 yrs		10. UNDER 1 YEAR IF UNDER 24 HRS Months 10 Days 10 Hours 10 Min 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lawrence Milanicz		14. MOTHER'S MAIDEN NAME Agnes Glinski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-01-0821	
17. INFORMANT Gilbert Gruszczynski - 1807 Aliceanna St.		Address #21231	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO (b) Bedridden, Perpheric Edema DUE TO (c) 170X (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Radical Rt. Mastectomy for Ca. of the Breast			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	
20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/26 , 1967 to 5/16 , 1967 , that (I) (we) last saw the deceased alive on 5/16 , 1967 , and that death occurred at 6:15p M, from causes and on the date stated above			
22a. SIGNATURE Roberto O. Ferrer M.D.		22b. DATE SIGNED 5-16-67	
22c. PHYSICIAN'S NAME (Type) Roberto O. Ferrer		22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/20/67	
23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR George A. Weber 705 S. Ann Street		25a. REC'D BY REGISTRAR Charles Judge DATE MAY 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06288

CERTIFICATE OF DEATH

06278

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		e. STREET ADDRESS <u>3626 Lochearn Dr</u>	
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Aloysius</u> Last <u>Gwyer</u>		4 DATE OF DEATH Month <u>5</u> Day <u>29</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10/3/86</u>
9 AGE (In years last birthday) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Pittsburgh, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Gwyer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bohland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>213-10-2601</u>	
17 INFORMANT <u>PATIENT'S CHART</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> DUE TO (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>BRONCHOPNEUMONIA</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>5/24</u> , 19 <u>67</u> , to <u>5/29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 29</u> 19 <u>67</u> , and that death occurred at <u>2:40</u> P.M. from causes and on the date stated above			
22a SIGNATURE <u>Evelyn L. Ramos M.D.</u>		22b. DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <u>EVELYN L. RAMOS, M.D.</u>		22d. ADDRESS <u>G.B.M.C., Towson 4</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6/1/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. CO. MD</u>
24. FUNERAL DIRECTOR <u>BURGER FUNERAL HOME 3634 FALLS RD</u>		25a. REC'D BY REGISTRAR <u>24 Ann Burger Hones</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>		DATE <u>JUN 2 1967</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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FOR STATE HEALTH DEPT.

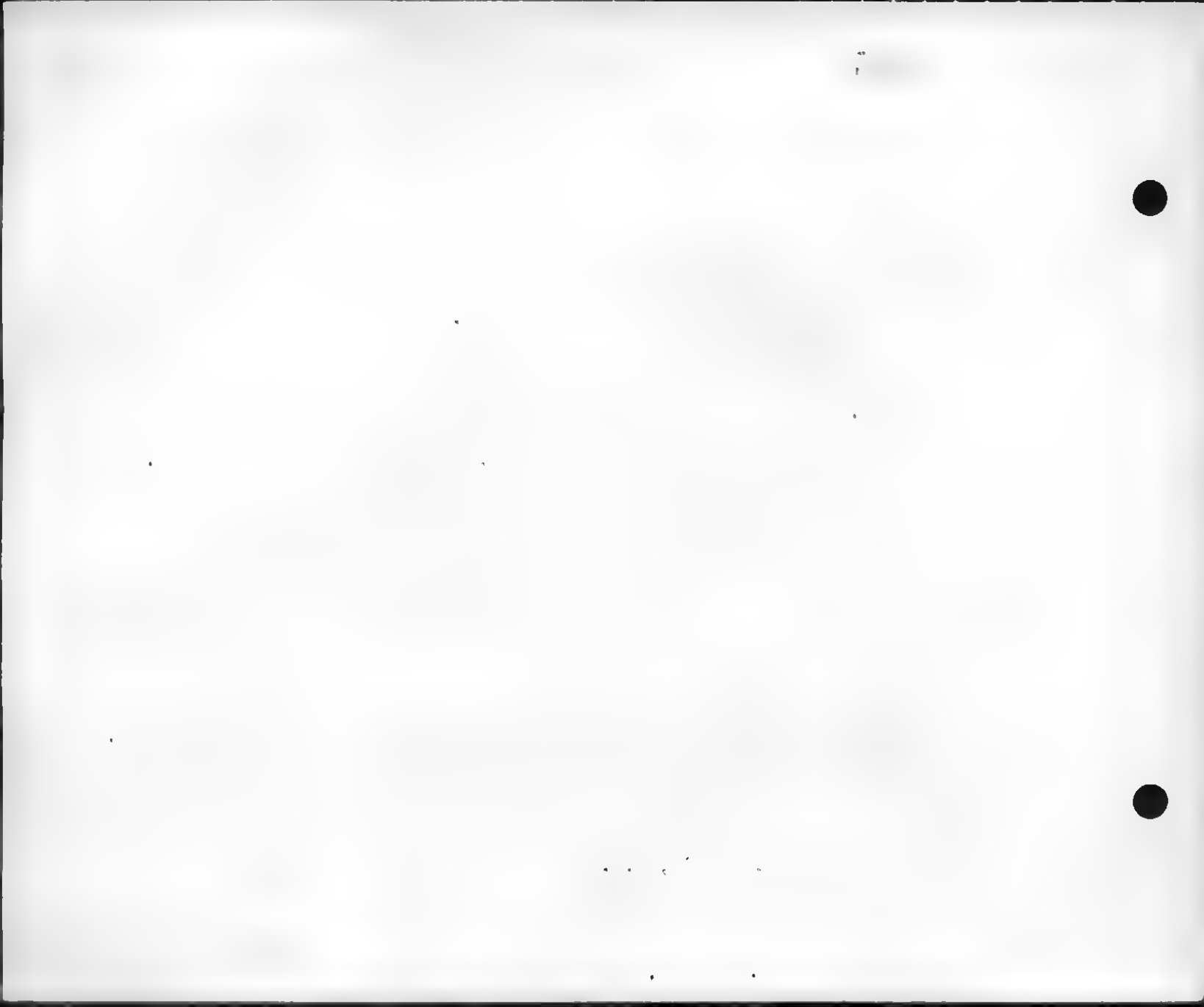
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06283

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00079

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 818 Fairway Drive				2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 818 Fairway Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First CHARLES Middle MATHIAS Last HAHN				4 DATE OF DEATH Pronounced Month 5 Day 3 Year 1967			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 12, '35	9 AGE (In years lost birthday) yrs 31	10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Jacob H. Hahn				14 MOTHER'S MAIDEN NAME Hilda Beutgen			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO Unknown		17. INFORMANT Mrs. Lillian J. Rosenberg Address Spring Lane 14 W. Cold			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wound of head 7/10A DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Shot self in head					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Unknown		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Home		20f. (City or town) (County) (State) Towson Balto. Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town or county)		22. DATE SIGNED 5-3-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 6, 1967	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery Baltimore		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland		23e. REGISTRAR'S SIGNATURE Charles Judge	
24 FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.		ADDRESS		25a. REGISTRAR'S SIGNATURE MAY 8 1967		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

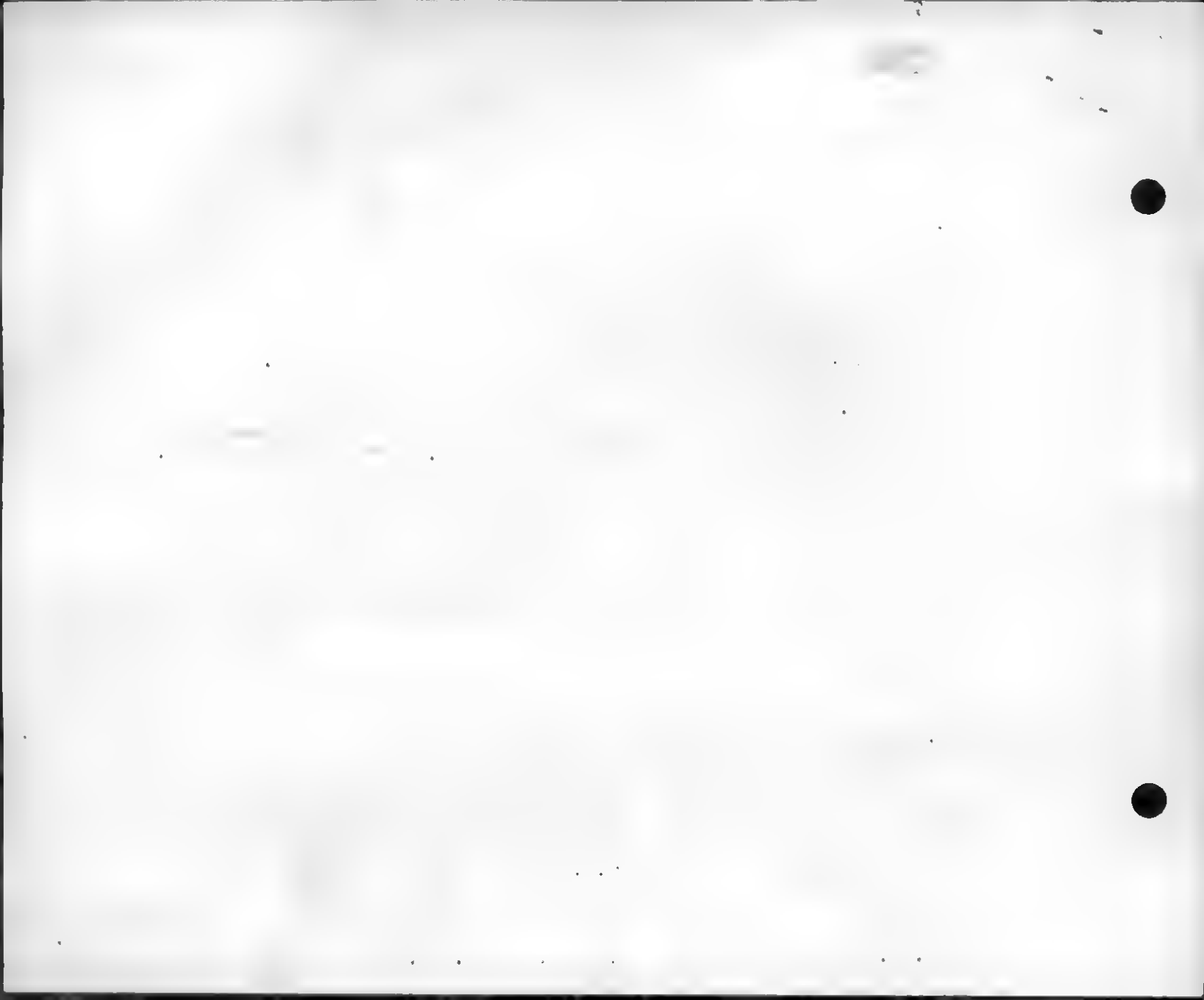
06290

00280

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN b. Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital - DOA				e. STREET ADDRESS 1644 XXXXXX Road 21204			
3. NAME OF DECEASED (Type or print) First Middle Last KENNETH FRANKLIN HAHN				4. DATE OF DEATH Month Day Year 5 28 1967			
5. SEX Male	6. CO. OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-40	9. AGE (In years last birthday) 26 yrs.	IF UNDER 1 YEAR Months Days Hours Min	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trainee-Manager		10b. KIND OF BUSINESS OR INDUSTRY Food		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert H. Hahn				14. MOTHER'S MAIDEN NAME Mary Jane Stine			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213 36 8962		17. INFORMANT Musatin Sarah L. Hahn 1644 XXXXXX Rd. 21204			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Craniocerebral injuries DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto which ran off road at Long Green and Hannibal Roads					
20c. TIME OF INJURY Month, Day, Year Hour, a.m. p.m. App. 12:21 AM 5-28 1967		20a. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE 		EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town or county)		22. DATE SIGNED 5-28-67	
23a. BURIAL CREMATION, or other disposition (Type) Burial		23b. DATE THEREOF 5-31-67		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Baltimore 6, Maryland.	
24. FUNERAL DIRECTOR Wm. E. Johnson, 8521 Loch Raven Bl. Balto. Md.				25a. REC'D BY REGISTRAR JUN 5 1967		25b. REGISTRAR'S SIGNATURE 	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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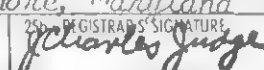
FOR STATE
HEALTH DEPT.

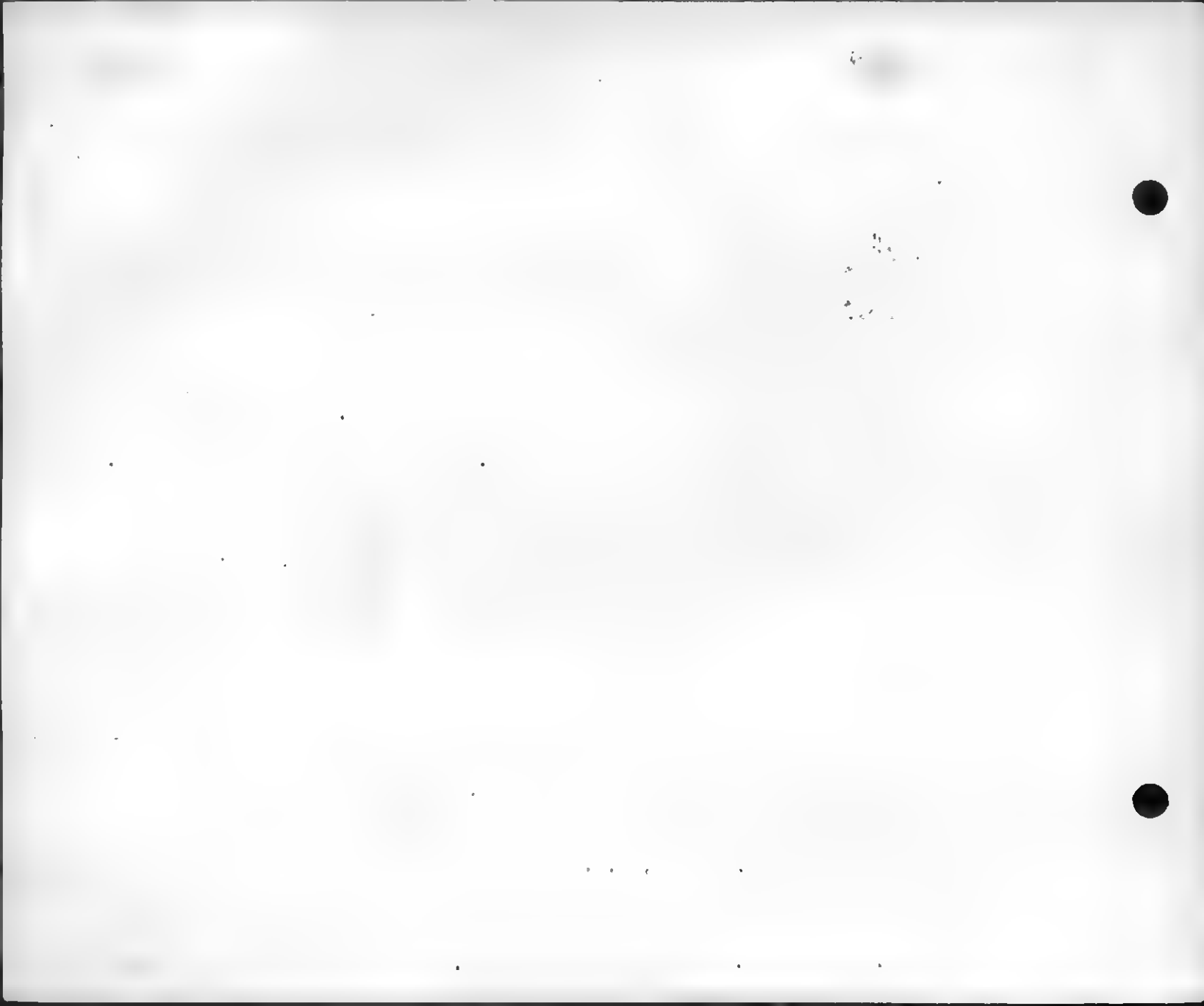
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36291

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

36291

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived first before admission) b STATE Maryland c COUNTY Baltimore			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 818 Fairway Drive				d STREET ADDRESS 818 Fairway Drive			
3 NAME OF DECEASED (Type or print) First MARY Middle LOUISE Last HAHN				4 DATE OF DEATH Pronounced 5 3 1967			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Mar. 26, 1935		9 AGE (In years last birthday) yrs. 32	10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Baltimore, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Leo A. Rosenberger				14 MOTHER'S MAIDEN NAME Lillian J. Jacobs			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO Unknown		17 INFORMANT Mrs. Lillian J. Rosenberger Address Spring Lane 14 W. Cold			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO Conditions, if any, which gave rise to immediate cause (b) DOA DUE TO stating the underlying cause lost (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II(a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Presumably shot by husband					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. Unknown		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f (City or town) (County) (State) Towson Balto. Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect an <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE 		EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 5-3-67	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 5/6/67		23c NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.				25a REGD BY REGISTRAR MAY 8 1967		25b REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36292

CERTIFICATE OF DEATH

100292

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Armacost Con Home Register Ave		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 912 Chestnut Hill Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Margaret Edna Hartig First Middle Last		4. DATE OF DEATH Month May Day 16 Year 1967	
5 SEX Female	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 5 1918
9 AGE (In years last birthday) 49 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY at home	
11 BIRTHPLACE (County & State or foreign country) Md		12 C. I. ZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frederick Wirth		14. MOTHER'S MAIDEN NAME Julia Martino	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17 INFORMANT Karl W Hartig		Address 912 Chestnut Hill Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Carcinomatosis 170X DUE TO (b) Carcinoma of breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 year 7 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from February , 1967, to May , 1967, that (I) (we) last saw the deceased alive on May 16 , 1967, and that death occurred at 7:15 PM , from causes and on the date stated above			
22a. SIGNATURE Loy M. Zimmerman MD		22b. DATE SIGNED 5/17/67	
22c. PHYSICIAN'S NAME (Type) Loy M. Zimmerman M.D.		22d. ADDRESS 3202 Harford Rd. Baltimore, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF May 18/67	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore
24. FUNERAL DIRECTOR Ullrich Funeral Homes		25a. REC'D BY REGISTRAR DATE MAY 22 1967	
ADDRESS 4210 Belair Road		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06293

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06283

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 709 Kingston, Rd. c. LENGTH OF STAY in lb 5 yrs.		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Baltimore, 21212	
3. NAME OF DECEASED (Type or print) William E. Haverstick First Middle Last 4. DATE OF DEATH Month May Day 21 Year 67		5. SEX M 6. COLOR OR RACE W. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 1, 1887 9. AGE (In years and birthday) 79 yrs IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Baker 10b. KIND OF BUSINESS OR INDUSTRY Baking		11. BIRTHPLACE (State or foreign country) Adams Co. Pa. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Addison Haverstick		14. MOTHER'S MAIDEN NAME Anna Rudisill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-36-6630	
17. INFORMANT Josephine Haverstick, 709 Kingston Rd. Address		18. CAUSE OF DEATH (Enter only one cause for item (a), one for (b), and one for (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DOE TO (b) Myocardial Infarction DUE TO (c) Coronary Arteriosclerotic Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): None	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. "City or town" (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles F. O'Donnell EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county) 5/21/67		22. DATE SIGNED 5/21/67	
23a. BURIAL CREMATION, EMBALMING (Specify) Burial		23b. DATE THEREOF May 24, 67	
23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION (City or town) (County) (State) Cockeysville, Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Tugson, Towson, Md. ADDRESS		25a. REC'D BY REGISTRAR MAY 26 1967 DATE 25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1648 FOREST PARK AVENUE		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE d. STREET ADDRESS 1648 FOREST PARK AVENUE	
3. NAME OF DECEASED (Type or print) ROSA E. HAYNIE First Middle Last 4. DATE OF DEATH 5/19/67 Month Day Year		5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH I/30/83 9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) VA. 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME CHARLES WALKER 14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. NO 17. INFORMANT FAMILY - SISTER Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA - RECTUM Conditions, if any, which gave rise to immediate cause (b) & GENERALIZED CARCINOMATOSIS. (a), stating the underlying cause last. (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/18 , 19 66 , to 5/19 , 19 67 , that (I) (we) last saw the deceased alive on 5/18 , 19 67 , and that death occurred at 3 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Norman R. Kleiman 22c. PHYSICIAN'S NAME (Type) NORMAN R. KLEIMAN		22b. DATE SIGNED 5/20/67 22d. ADDRESS 3803 Edmondson Ave	
23a. BURIAL, CREMATION, REMOVAL (Specify) B		23b. DATE THEREOF 5/22/67	
23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE		23d. LOCATION (City, town or county) (State) BALTIMORE MD	
24. FUNERAL DIRECTOR'S SIGNATURE W. C. Kelly - 237 Tatapsee Ave ADDRESS		25a. REC'D BY REGISTRAR MAY 22 1967 25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06295

CERTIFICATE OF DEATH

06285

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN		c. LENGTH OF STAY IN TB 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTO. COUNTY GEN. HOSP.				d. STREET ADDRESS 6003 WINDSOR MILL RD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LULA Middle B. Last HEARN				4. DATE OF DEATH Month 5 Day 2 Year 19 67			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/30/84	9. AGE (In years last birthday) 83 yrs	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PATRICK ALBION				14. MOTHER'S MAIDEN NAME ROSA BYRD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT Address Edward D. Hearn 6003 Windsor Mill Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) REFRACTORY CONGESTIVE HEART FAILURE 4221 DUE TO ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 10 1/2 HRS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/29/67 , 19 19 to 5/2/67 , 19 19 , that (I) (we) last saw the deceased alive on 5/2/67 , 19 19 , and that death occurred at 10:15 PM , from causes and on the date stated above.							
22a. SIGNATURE Dr. Milton Schlenoff				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-2-67	
22c. PHYSICIAN'S NAME (Type) MILTON SCHLENOFF				22d. ADDRESS BALTO COUNTY HOSP			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/6/67		23c. NAME OF CEMETERY OR CREMATORY Pargons		23d. LOCATION (City or Town) (County) (State) Salisbury Maryland	
24. J. I. STANSBURY 6417 Windsor Mill Rd. Funeral Director				25a. REC'D BY REGISTRAR MAY 4 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1000



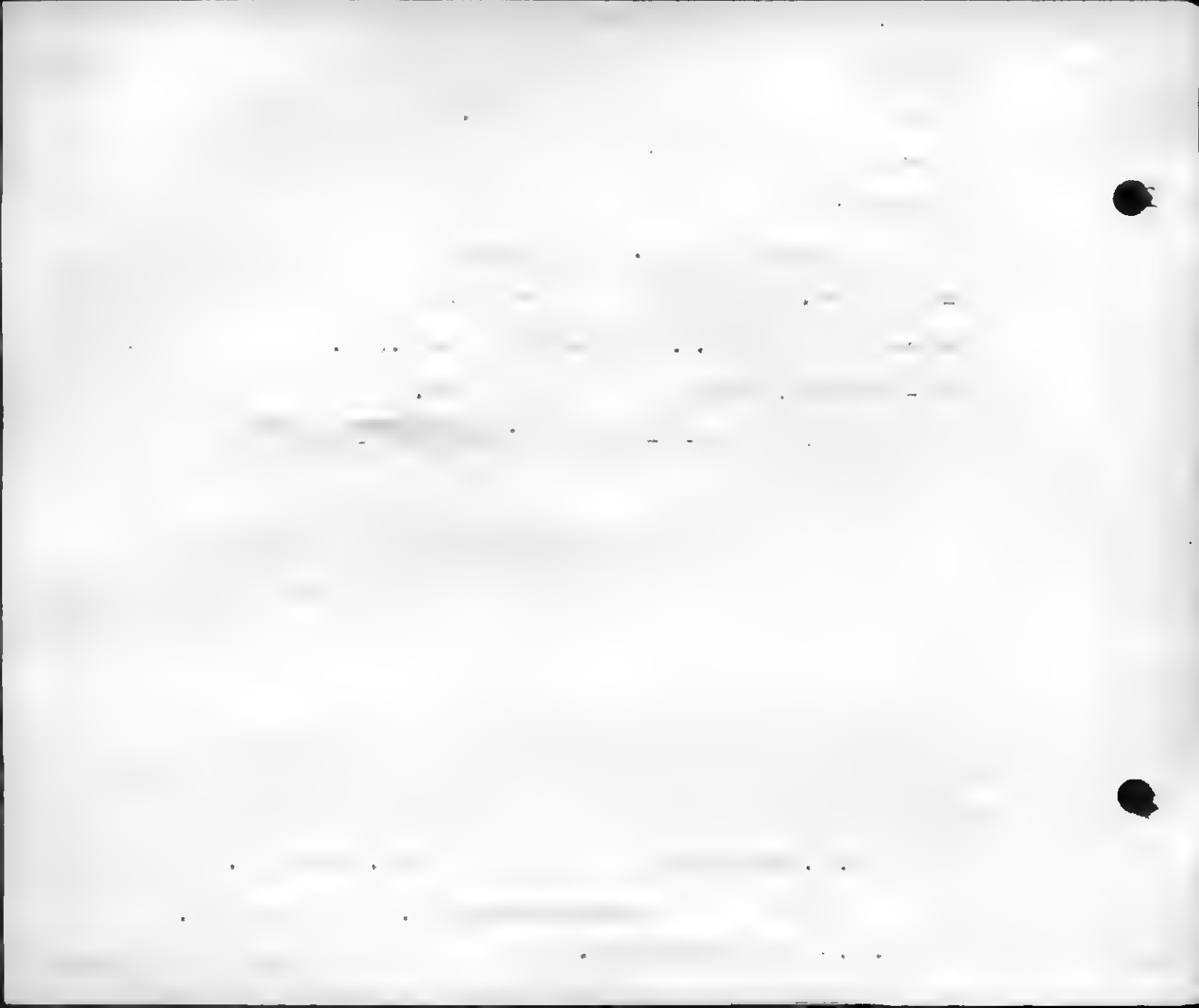
CERTIFICATE OF DEATH

Reg. Dist. No.

15286

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 625 Myers Drive		d. STREET ADDRESS 625 Myers Drive	
3. NAME OF DECEASED (Type or print) First William Middle S. Last Herrick		4. DATE OF DEATH Month May Day 20 Year 19 67	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1887
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Civil Service	
11. BIRTHPLACE (State or foreign country) Balte., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Late - William J. Herrick		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO 219-14-0967	
17. INFORMANT Mrs. Joseph Galkas		Address 625 Myers Drive - 21228	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Myocardial Failure 416 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Cardio-vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 36 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Laryngectomy for Ca of Larynx		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part of Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1966 to May 20, 1967 , that I last saw the deceased alive on May 19, 1967 , and that death occurred at 7 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. MacLaughlin		ADDRESS (Street, city or town, state) DATE SIGNED 303 N. Rolling Rd. 5/20/67	
PHYSICIAN'S NAME (Type) D. C. MacLaughlin		303 N. Rolling Rd.	
22a. BURIAL, CREMATON, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/23/67	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F. D. - 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR MAY 22 1967	
24b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06297

06287

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN b				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234 d. STREET ADDRESS 2032 E. Joppa R.			
3. NAME OF DECEASED (Type or print) First Middle Last Louise Sproull HILL				4. DATE OF DEATH Month Day Year May 11, 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 23, 1888	
9. AGE (In years last birthday) 78 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William A. Sproull				14. MOTHER'S MAIDEN NAME Elizabeth Chipley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO 213-12-2606A		17. INFORMANT William S. Hill Address Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Due to Septicemia (b) Respiration (c) 25% Body 3rd Burns						INTERVAL BETWEEN ONSET AND DEATH 17 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Clothing caught fire Resching over Electric Stove					
21. TIME OF INJURY Month Day Year 2:30 am 4/11/67		22. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		24. CITY OR TOWN (County) (State) Carney Balto Md.	
25. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles L. O'Donnell M.D. EXAMINER'S NAME (Type) CHARLES L. O'DONNELL, M.D.				26. DATE SIGNED 5/11/67			
27. BURIAL, CREMATION REMOVAL (Specify) Burial		28. DATE THEREOF 5-13-67		29. NAME OF CEMETERY OR CREMATORY Moreland Memorial		30. LOCATION (City or Town) (County) (State) Baltimore Co. Md.	
31. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. ADDRESS 3905 York Rd., Balto				32. REC'D BY REGISTRAR MAY 15 1967		33. REGISTRAR'S SIGNATURE Charles Judge	

Copy of this to be sent to Chief Medical Examiner
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.
Autopsy performed by Dr. Charles L. O'Donnell, M.D.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

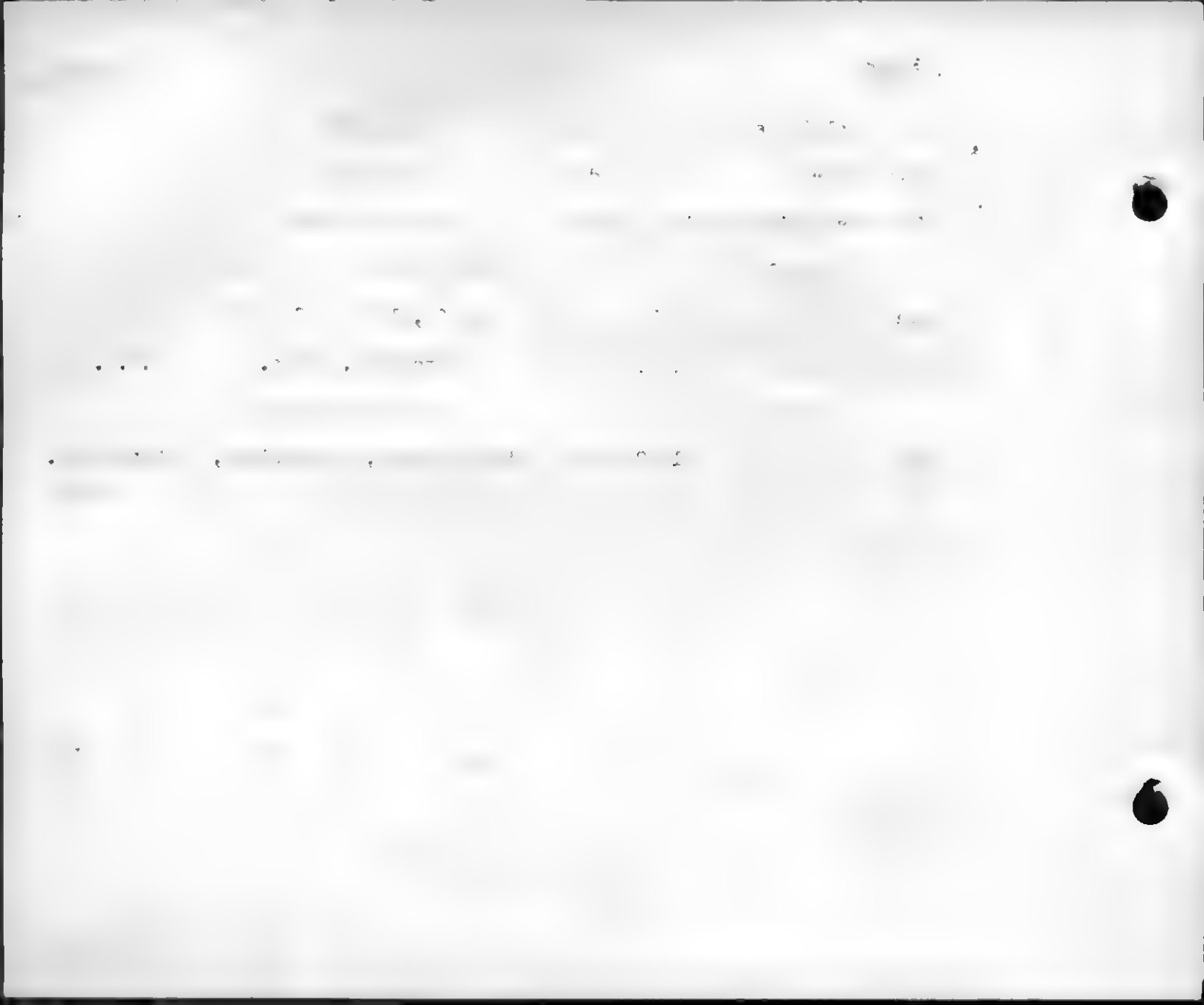
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #6 Film #338-546467

36298

CERTIFICATE OF DEATH

36298

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				e. STREET ADDRESS 594A Yale Street			
3. NAME OF DECEASED (Type or print) First ALBERT Middle L Last HILLIARD				4. DATE OF DEATH Month May Day 30 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1889	9. AGE (In years last birthday) yrs 78	10. FUNERAL 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SOLDIER		10b. KIND OF BUSINESS OR INDUSTRY U. S. ARMY		11. BIRTHPLACE (County & State, or foreign country) Wilmerding, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk				14. MOTHER'S MAIDEN NAME VICTORIA MN: OGROWSKI			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 218 26 33 06		17. INFORMANT Address Clinical Rcds, VA Hospital, Ft Howard Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) CORONARY HEART DISEASE						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that A (this hospital) attended the deceased from May 24 , 19 67 , to May 30 , 19 67 , that A (we) lost saw the deceased alive on May 30 , 19 67 , and that death occurred at 10:30 AM from causes and on the date stated above.							
22a. SIGNATURE <i>Peter V. Juvan</i>				22b. DATE SIGNED 5/31/67		22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/2/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR MC CULLY FUNERAL HOME				25a. REC'D BY REGISTRAR JUN 2 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

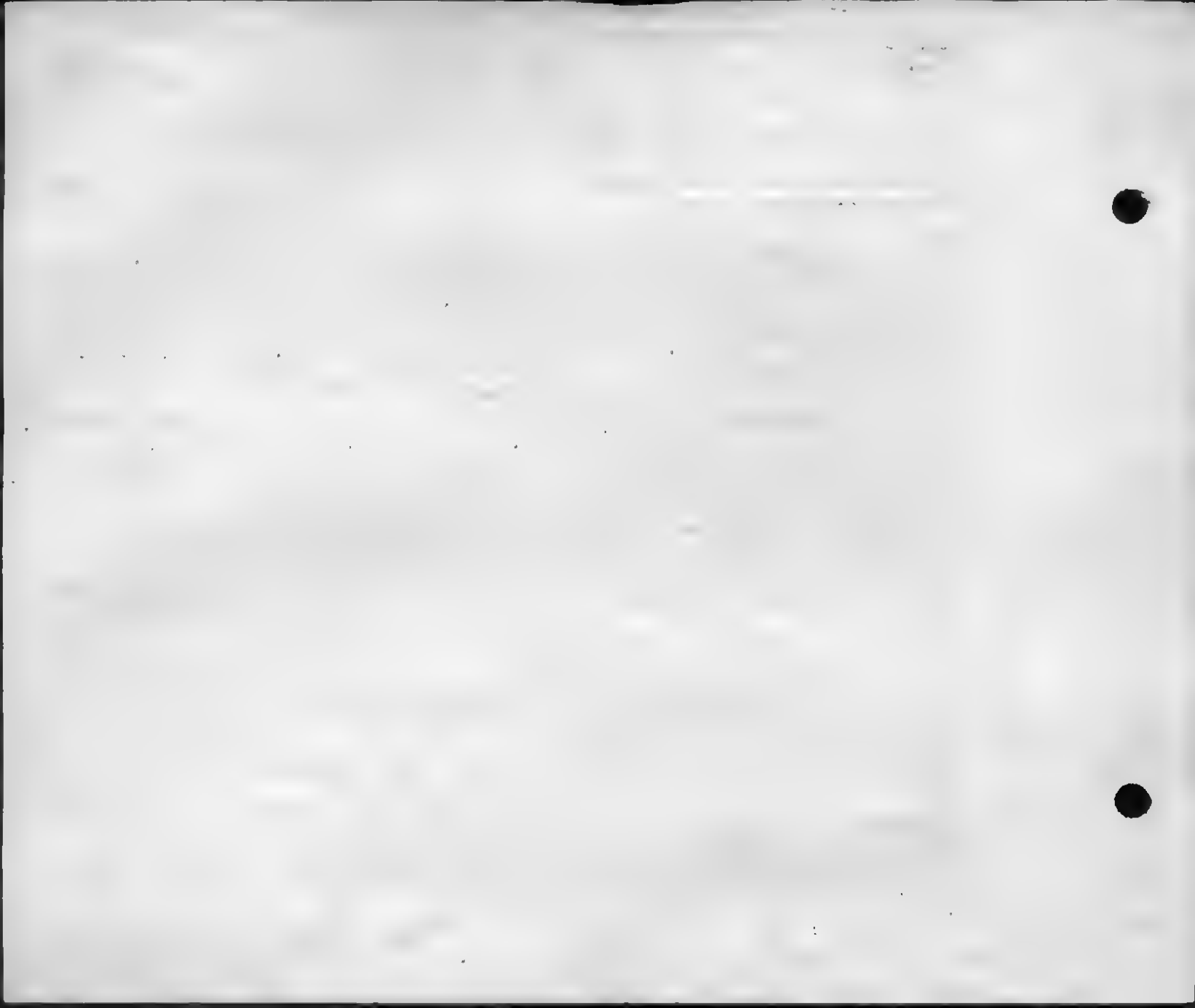
06299

CERTIFICATE OF DEATH

06289

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11001 Reisterstown Road</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> d. STREET ADDRESS <u>11001 Reisterstown Road</u>										
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN BERNARD HOFF</u>			4. DATE OF DEATH Month Day Year <u>May 11, 1967</u>										
5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>										
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Nov. 18, 1887</u>										
9. AGE (In years last birthday) <u>79</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Mins.</td> </tr> </table>			IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Mins.			
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Mins.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Driver</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Belto. Transit</u>										
11. BIRTHPLACE (County & State, or foreign country) <u>Owings Mills, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>										
13. FATHER'S NAME <u>John Hoff</u>			14. MOTHER'S MAIDEN NAME <u>Mary Lee Cantwell</u>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>213-05-9114</u>										
17. INFORMANT <u>Mrs. Kate E. Hoff, 11001 Reisterstown Rd., Owings Mills, Md.</u>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Cardiovascular arteriosclerotic disease</u> DUE TO (c) <u>Decompensated</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>													
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>													
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)													
20f. [City or town] (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from <u>1-1-30</u> <u>5-11-67</u> , that (I) (we) last saw the deceased alive on <u>5-13-67</u> , and that death occurred at <u>11:15</u> M. from the causes and on the date stated above													
22a. SIGNATURE <u>James G. Hoff</u>													
22c. PHYSICIAN'S NAME (Type) <u>James G. Hoff</u>													
22d. ADDRESS <u>Reisterstown, Md.</u>													
22e. DATE SIGNED <u>5-13-67</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>													
23b. DATE THEREOF <u>5/13/67</u>													
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>													
23d. LOCATION (City, town or county) <u>Pikesville, Md.</u>													
24 FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Eckhardt</u>													
ADDRESS <u>Owings Mills, Md.</u>													
25a. REC'D BY REGISTRAR <u>MAY 15 1967</u>													
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>													

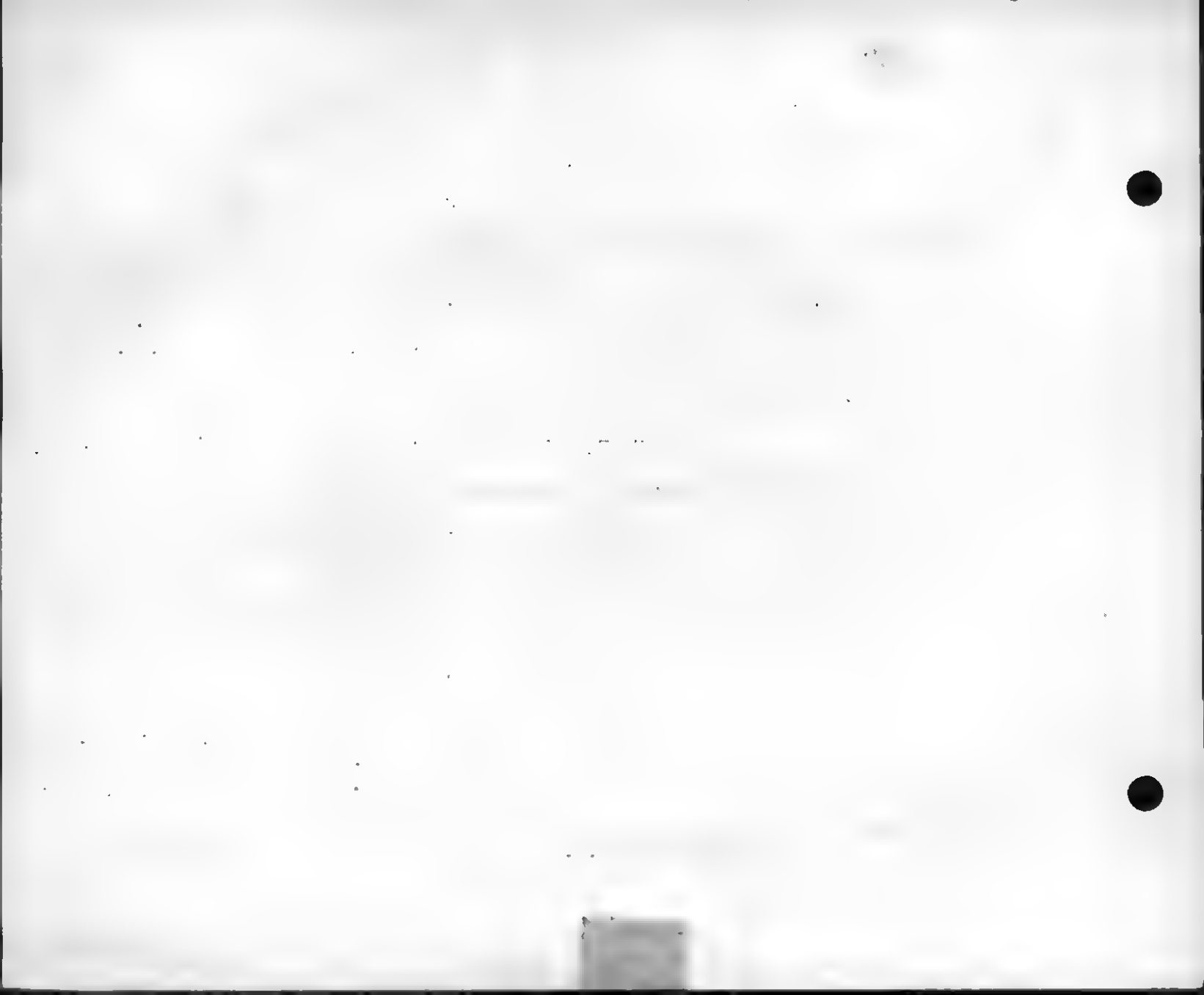
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 shall be retained by the hospital or attending physician.
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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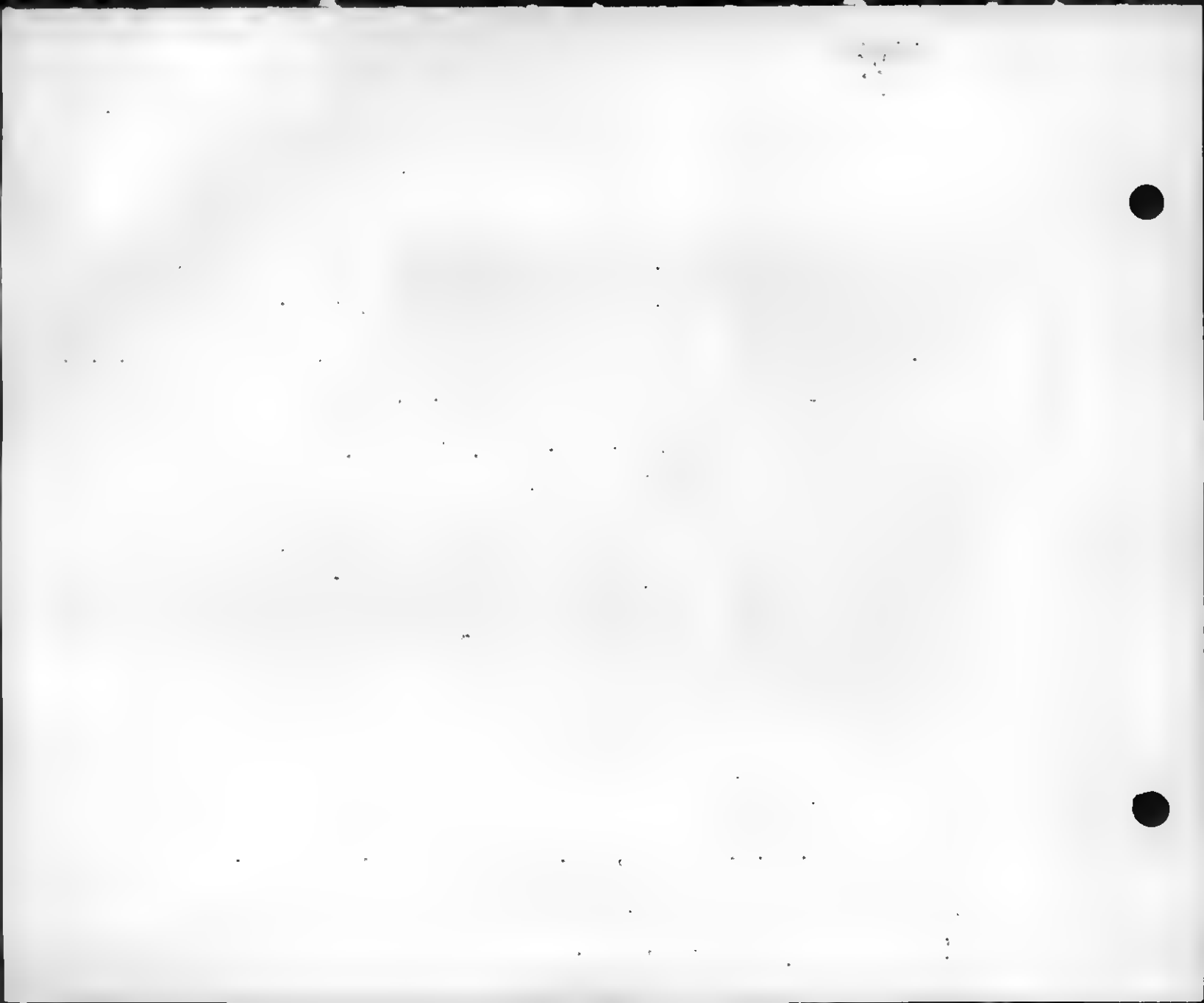
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN ID 38yr11mth8dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 120 North Wolfe Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Samuel Middle _____ Last Hoffman			4. DATE OF DEATH Month May Day 23 Year 19 67						
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 1899		9. AGE (in years last birthday) 67 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Samuel Hoffman					14. MOTHER'S MAIDEN NAME Annie Formen				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____			16. SOCIAL SECURITY NO. 219-54-3163-T		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address _____				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									INTERVAL BETWEEN ONSET AND DEATH _____
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that 4 (this hospital) attended the deceased from June 15 , 19 68 to May 23 , 19 67 , that he (we) last saw the deceased alive on May 23 , 19 67 , and that death occurred at 7:25 am , from the causes and on the date stated above.									
22a. SIGNATURE Stella Wachslar			22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228		22b. DATE SIGNED 5-23-67		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 5/26/1967		23c. NAME OF CEMETERY OR CREMATORY Mt. CARMEL		23d. LOCATION (City, town or county) BALTO MD. (State) _____		
24. FUNERAL DIRECTOR SYLVAN S. LEWIS & SON, INC - GARRISON MD.			25a. REC'D BY REGISTRAR MAY 29 1967		25b. REGISTRAR'S SIGNATURE J. Charles Jones				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06301 CERTIFICATE OF DEATH 06291									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rodgers Forge c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 37 Dunkirk Road					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 37 Dunkirk Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) CHARLOTTE T. HOGAN					4. DATE OF DEATH May 27, 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 8, 1880		9. AGE (In years last birthday) 86 yrs. IF UNDER 1 YEAR: Months 8 Days 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Rebstock					14. MOTHER'S MAIDEN NAME Charlotte				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 220-07-8044		17. INFORMANT Mrs. Marie H. LaFleur			Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 260X DUE TO (b) Atherosclerosis of Arteries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) A white rupture								INTERVAL BETWEEN ONSET AND DEATH 2 yrs 16 yrs 16 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis of Left Coron.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June , 19 52 , to May , 19 67 , that (II) (we) last saw the deceased alive on May 10 1967 , and that death occurred at 5 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Dr. E.P. Coffay, Jr.					22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) Dr. E.P. Coffay, Jr.	
22d. ADDRESS 3100 St. Paul St. Baltimore					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-31-67		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home, Inc. 6500 York Rd.					25a. REC'D BY REGISTRAR JUN 1 1967		25b. REGISTRAR'S SIGNATURE James Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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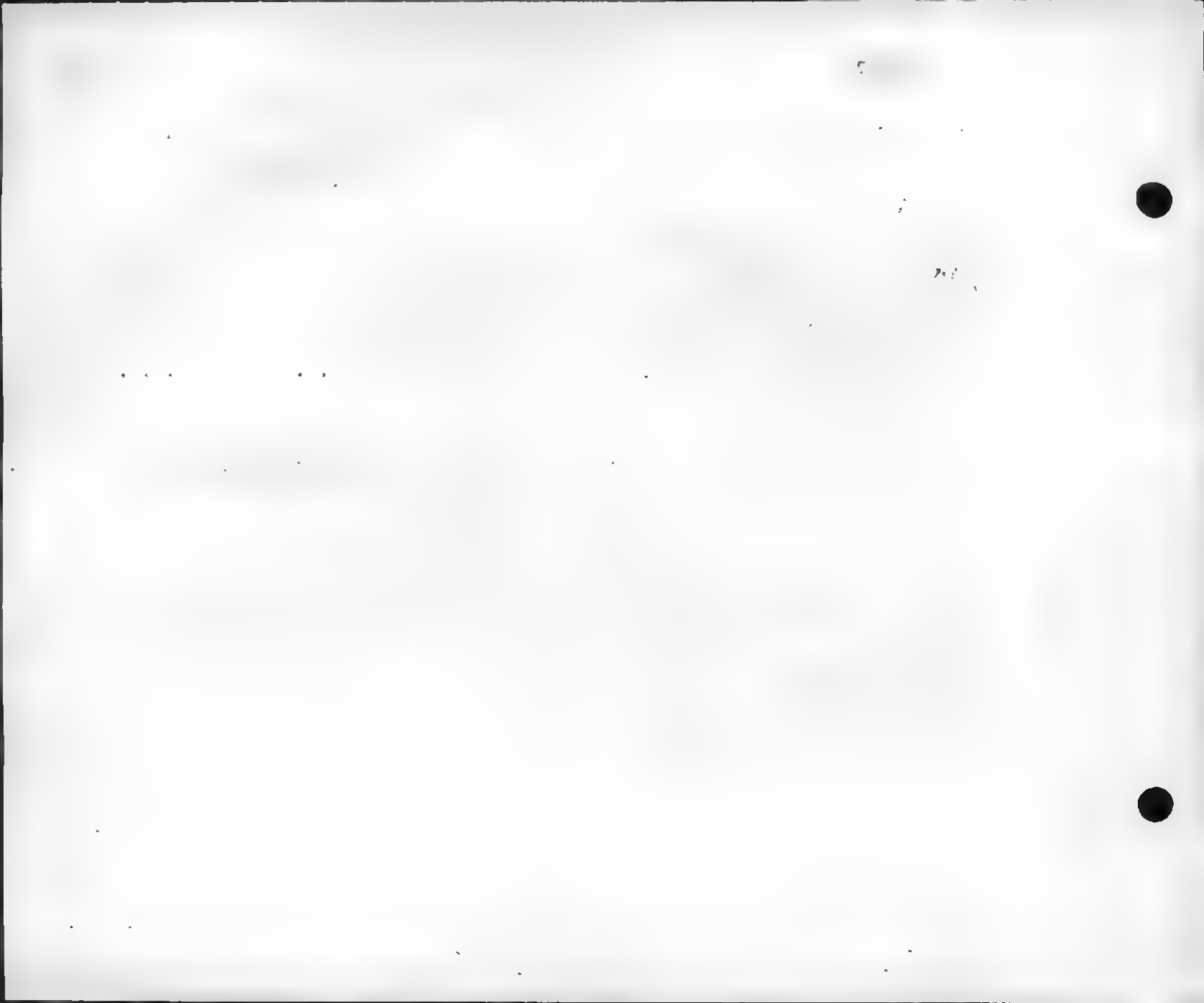
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06302

CERTIFICATE OF DEATH

06292

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Pr. George's		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c LENGTH OF STAY IN 1b 7 months	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Carrollton		
d NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Spring Grove State Hospital			d STREET ADDRESS 6109 85th Place		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) Margaret Cora Holson			4 DATE OF DEATH Month MAY Day 24 Year 1967		
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 17, 1910	9 AGE (In years last birthday) 57 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Retired Sales Clerk		10b KIND OF BUSINESS OR INDUSTRY Dept. Store		11 BIRTHPLACE (County & State, or foreign country) Washington D.C.	
13. FATHER'S NAME Vernon Hayden			14. MOTHER'S MAIDEN NAME Mary King		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-01-5526		17. INFORMANT Barbara A. Petro Address 6109 85th Place Records Spring Grove State Hospital	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4221 DUE TO CARDIAC FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) ARTERIOSCLEROSIS GENERALIZED AND SEVERE					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 27, 1966 to MAY, 24, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 24 1967 , and that death occurred at 6:33 P.M. from causes and on the date stated above.					
22a. SIGNATURE Morris Meiller		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b DATE SIGNED May 24, 1967		
22c. PHYSICIAN'S NAME (Type) MORRIS MEILLER M.D.		22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF May 27, 1967	23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d LOCATION (City or Town) (County) (State) Prince Georges Co., Md.		
24a FUNERAL DIRECTOR Thomas Schuchman		ADDRESS 8434 Georgia Avenue		25a REC'D BY REGISTRAR Charles Judge	25b REGISTRAR'S SIGNATURE Charles Judge
24b Warner E. Humphrey, Inc.		Silver Spring, Md.		DATE MAY 26 1967	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

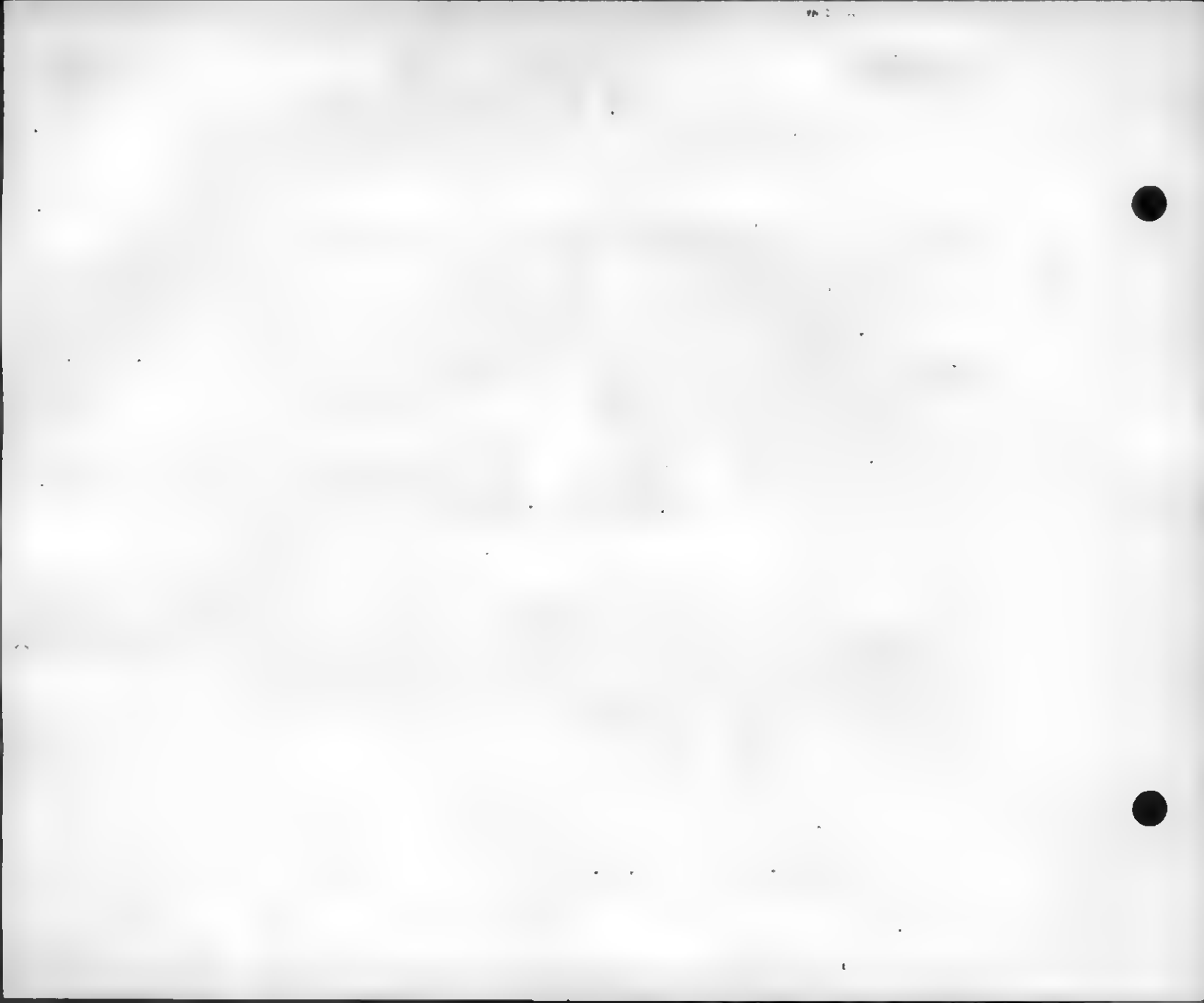
06303

CERTIFICATE OF DEATH

00293

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN b 49 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 4302 KOLB AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last HENRY ALLARD HOLT		4. DATE OF DEATH Month Day Year MAY 10 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/11/09
9. AGE (In years last birthday) 58 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR & SALESMAN		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (County & State, or foreign country) LOUISVILLE, KENTUCKY		13. CITIZEN OF WHAT COUNTRY U. S. A.	
14. FATHER'S NAME WILLIAM HOLT		15. MOTHER'S MAIDEN NAME DAISY HOPKINS	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES HW II		17. SOCIAL SECURITY NO. 215 03 10 95	
18. INFORMANT CLINICAL RECORDS VAH FORT HOWARD, MARYLAND		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF THE LIVER DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 22, 19 67 to MAY 10, 19 67 that (I) (we) last saw the deceased alive on MAY 10, 19 67 , and that death occurred at 7:30 AM from causes and on the date stated above.			
22a. SIGNATURE <i>John D. Talbert</i>		22b. DATE SIGNED 5-10-67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/12/67	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or town) (County) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG		25a. REC'D BY REGISTRAR 6009 HARFORD RD. BALTIMORE, MARYLAND	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE MAY 15 1967	

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HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

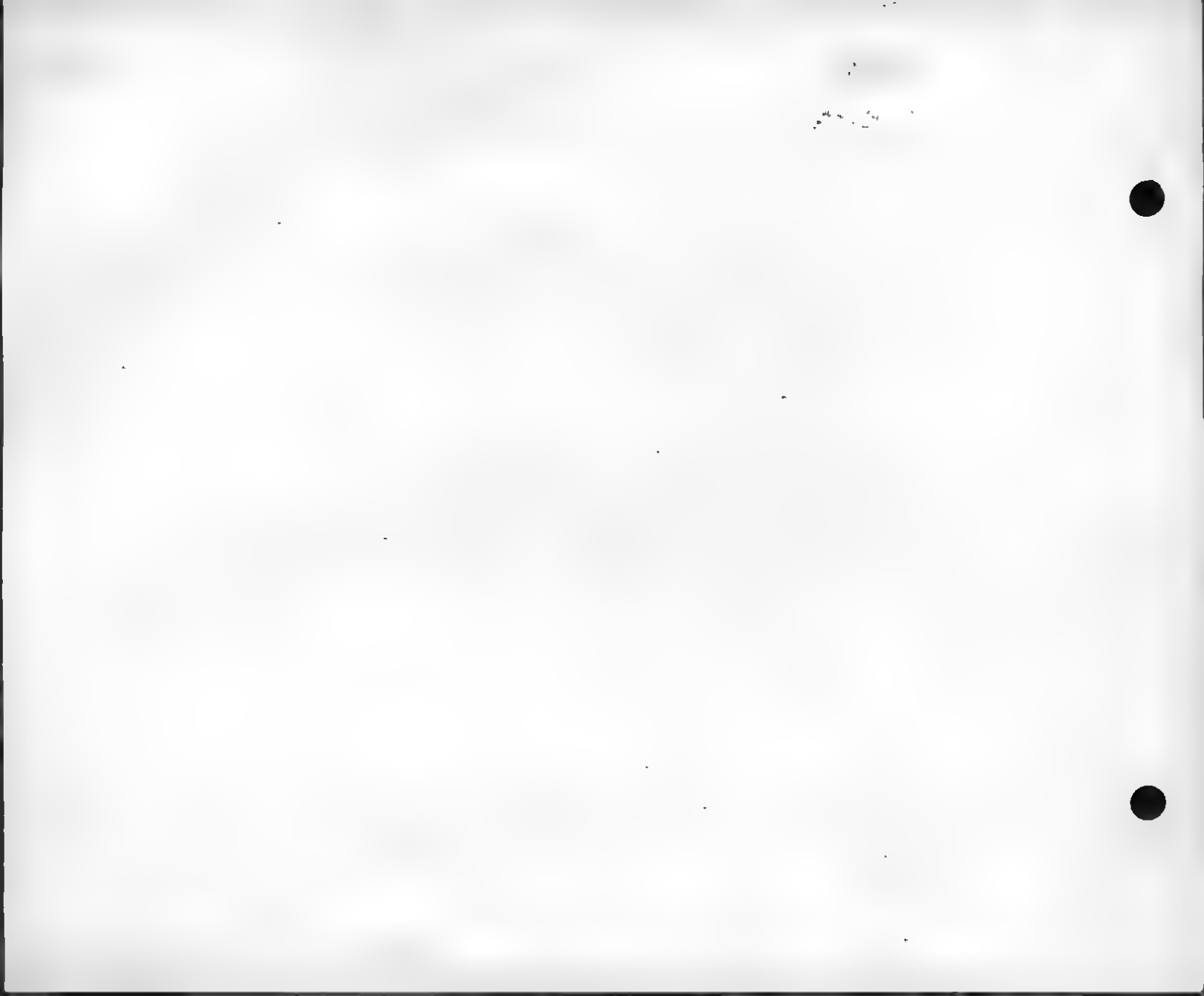
CERTIFICATE OF DEATH

DE 294

06304

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center				d. STREET ADDRESS 3725 Fairhaven Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES FRANCIS HOLY				4. DATE OF DEATH Month Day Year 5 15 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/5/01		9. AGE (In years last birthday) 66 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Holy				14. MOTHER'S MAIDEN NAME Nocar Marie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-44-6632		17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary emboli DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive and arteriosclerotic cardiovascular disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 min.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/8, 1967 , to 5/15, 1967 , that (I) (we) last saw the deceased alive on 5/15, 1967 , and that death occurred at 6 P.M. from causes and on the date stated above.							
22a. SIGNATURE <i>John E. Adams</i> M.D.				22b. DATE SIGNED MAY 16/1967		22c. PHYSICIAN'S NAME (Type) JOHN E. ADAMS	
22d. ADDRESS 6701 North Charles Street Balto. 21204							
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE THEREOF 5/19/67		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem		23d. LOCATION (City or Town) (County) (State) A A Co Md	
24. FUNERAL DIRECTOR McCully F H 237 Patapsco Ave 21225				25a. REC'D BY REG STRAR MAY 19 1967		25b. REG STRAR'S SIGNATURE <i>Charles Judge</i>	



06905

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20 M 1/66



06306

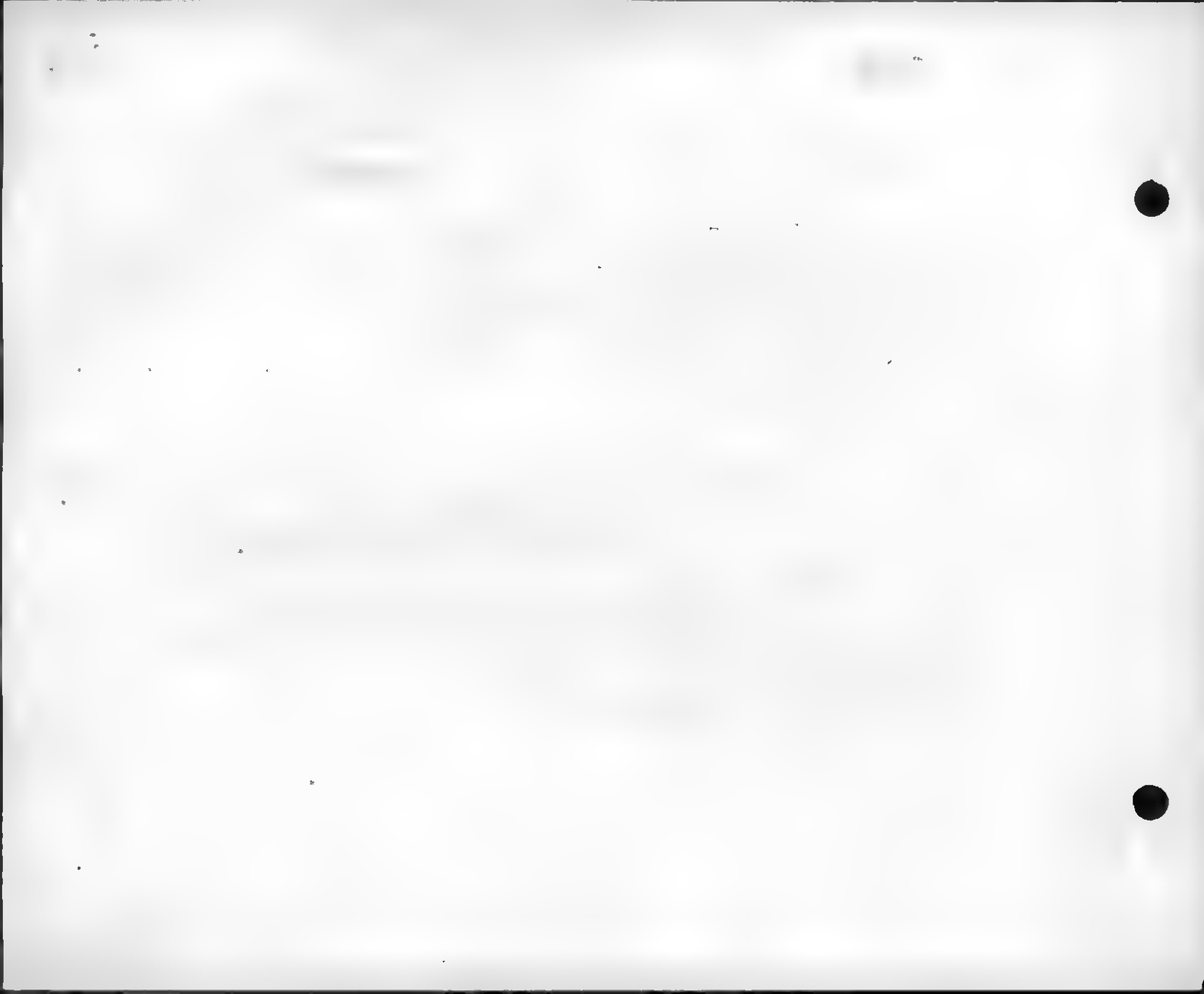
CERTIFICATE OF DEATH

06296

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b COUNTY Baltimore			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c LENGTH OF STAY IN 1b (2yrs 11 mo. 14 days)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House in the Pines- Catonsville				d. STREET ADDRESS 242 Clyde Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Camilla E. Hopkins				4 DATE OF DEATH Month May Day 27 Year 1967			
5 SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8 DATE OF BIRTH June 14, 1877	
9. AGE (In years last birthday) 89 yrs		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS Hours 0 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11 BIRTHPLACE (County & State, or foreign country) Carroll County, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13 FATHER'S NAME Augustus Selby				14. MOTHER'S MAIDEN NAME Mary Ridgely			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO None		17. INFORMANT Catonsville, Md. 21228 Mrs. Frank J. Willey Jr. 109 Rosewood Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) Congestive heart failure							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Arteriosclerotic C V D, Marked, generalized							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
Pneumonia, left lower lung							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
INTERVAL BETWEEN ONSET AND DEATH 1 mo.							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/13/64 , 19__, to 5/27/67 , 19__, that (I) (we) last saw the deceased alive on 5/11/67 , 19__, and that death occurred at 2:10 AM , from causes and on the date stated above.							
22a. SIGNATURE <i>Herbert J. Levickas</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/29/67	
22c. PHYSICIAN'S NAME (Type) Herbert J. Levickas				22d. ADDRESS 1073 Maiden Choice Lane Balto. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 29, 1967		23c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery		23d. LOCATION (City or Town) (County) (State) Howard County, Maryland	
24. FUNERAL DIRECTOR Easton Funeral Home				ADDRESS Catonsville, Md.		25a. REC'D BY REGISTRAR DATE MAY 31 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06307

CERTIFICATE OF DEATH

06307

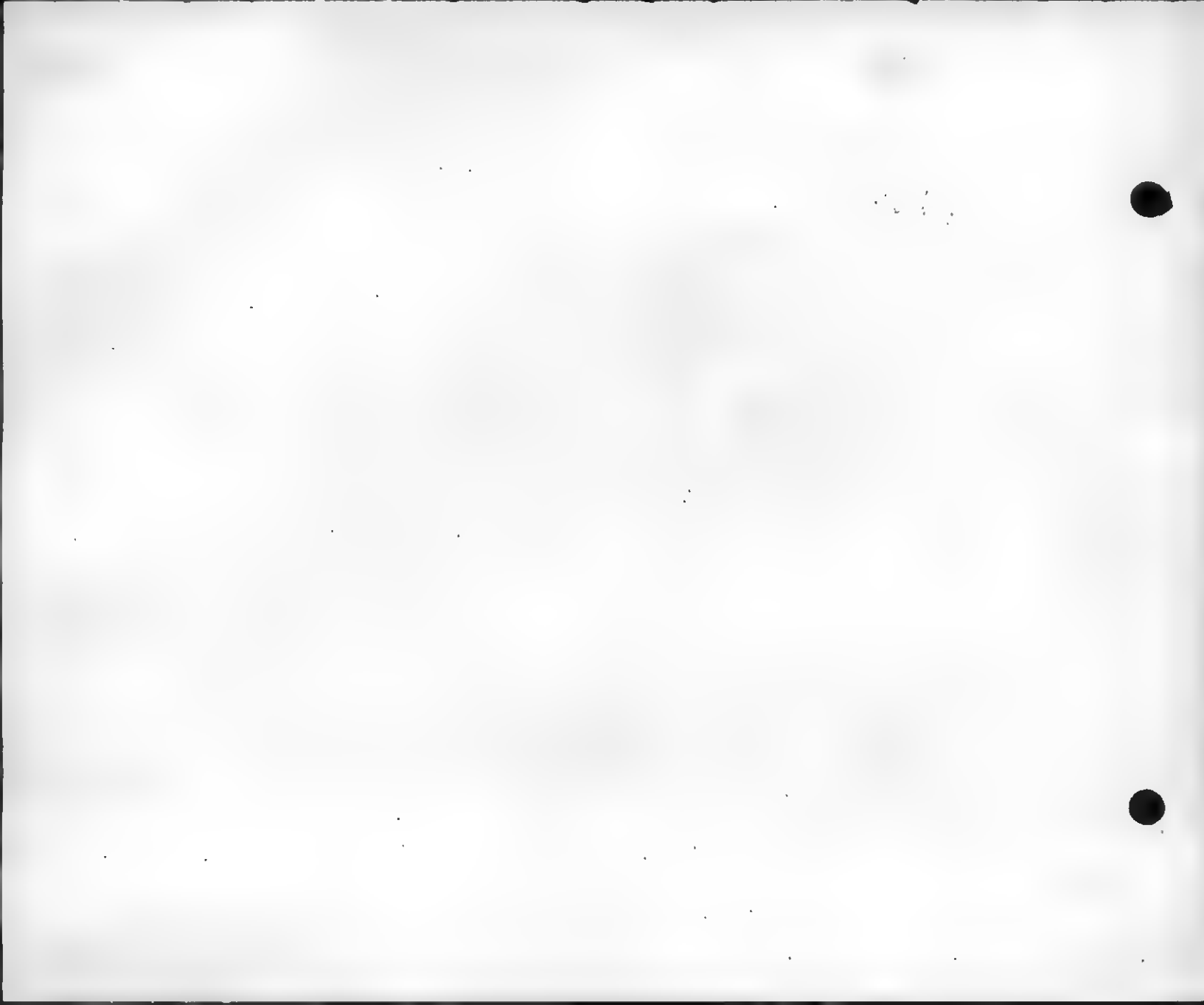
1 PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD b. COUNTY BALTI.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN 1b 11 weeks 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS 1716 WILLOW AVE.	
3 NAME OF DECEASED (Type or print) First Middle Last JAMES PINDELL HOWARD		4 DATE OF DEATH Month Day Year 5 14 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6/27/24
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER - LABORER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	9 AGE (In years last birthday) 42 yrs
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK HOWARD		14. MOTHER'S MAIDEN NAME EMMA HEDERICK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO 311-05-2101	
17. INFORMANT Records, Mount Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4321 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CEREBRAL INFARCTION DUE TO (c) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH ACUTE MONTHS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ABDOMINAL AORTIC Aneurysm		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/24, 1967 to 5/14, 1967 , that (I) (we) last saw the deceased alive on 5/13, 1967 , and that death occurred at 0830 AM , from causes and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 5/14/67	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	MAY 17, 1967	Jessop's Cemetery	Cockersville, Md.
24. FUNERAL DIRECTOR John R. Jones' Son, Towson, Md.		25a. REC'D BY REGISTRAR DATE MAY 18 1967	
		25b. REGISTRAR'S SIGNATURE James Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
26308		Items #6 & 9 File #3309 6/2/67 DC									
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>103 PARK DRIVE</u>						d. STREET ADDRESS <u>103 PARK DRIVE</u>					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
		<u>JAMES</u>		<u>G.</u>		<u>HOWELL</u>		<u>5</u>		<u>24</u> 19 <u>67</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 7 1899</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOCTOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MEDICINE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>AITONA PENN.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE A.</u>						14. MOTHER'S MAIDEN NAME <u>MARGARET CONDRIEN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. HOWELL</u>				Address <u>103 PARK DRIVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u> DUE TO (b) <u>BRONCHOGENIC CARCINOMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 MOS.</u> <u>6 MOS.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>DEC 6, 1966</u> to <u>MAY 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAY 24, 1967</u> , and that death occurred at <u>7:40 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>John H. Tuohy</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/24/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOHN H. TUOHY, M.D.</u>						22d. ADDRESS <u>ST. AGNES HOSP, BALTO 21294D</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/27/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OLD TRINITY</u>		23d. LOCATION (City, town or county) (State) <u>CHURCH CREEK MD</u>					
24. FUNERAL DIRECTOR <u>FARLEY-CAVANAUGH</u>				ADDRESS <u>6601 FREDERICK</u>		25a. REC'D BY REGISTRAR <u>MAY 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06303

06799

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

SHIPPED TO: C. E. EDWARDS FUNERAL HOME, BOWLING GREEN, VIRGINIA

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 113 DAYS		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BALTIMORE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1225 W. BALTIMORE STREET		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First JAMES Middle LYNN Last HUDSON				4 DATE OF DEATH Month MAY Day 24 Year 1967			
5 SEX MALE		6 COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH AUGUST 12, 1909	
9 AGE (in years last birthday) 57 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11 BIRTHPLACE (County & State, or foreign country) CAROLINE COUNTY, VIRGINIA	
12 CITIZEN OF WHAT COUNTRY? U.S.A.				13 FATHER'S NAME EUGENE HUDSON			
14 MOTHER'S MAIDEN NAME MAUDE ESLECK				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II			
16 SOCIAL SECURITY NO 218 07 56 57		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC PULMONARY EMPHYSEMA WITH RESPIRATORY FAILURE DUE TO (b) PULMONARY TUBERCULOSIS, FAR ADVANCED, INACTIVE DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) COR PULMONALE							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 1/31/67 , 19__ to 5/24/67 , 19__ that (X) (we) last saw the deceased alive on 5/24/67 , 19__, and that death occurred at 8:00P M, from causes and on the date stated above.							
22a. SIGNATURE <i>Peter V. Juvan</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/25/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 5-28-67		23c. NAME OF CEMETERY OR CREMATORY SPARTA CEMETERY		23d. LOCATION (City or town) (County) (State) SPARTA, VIRGINIA	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR ELROY O WILSON FUNERAL HOME		25b. REGISTRAR'S SIGNATURE <i>for Charles Judge</i>		DATE MAY 26 1967	
ADDRESS ORLEANS ST. BALTIMORE, MD.							



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VR A15 (4)
20 M 1/66

MD
7

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06310

CERTIFICATE OF DEATH

06300

1 PLACE OF DEATH a COUNTY Baltimore County		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Worcester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c LENGTH OF STAY in 1b 2 1/2 mo.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville	
3 NAME OF DECEASED (Type or print) WALTER JAMES HUDSON		d STREET ADDRESS RFD.	
e RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4. DATE OF DEATH Month 5 Day 10 Year 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11.22.1915
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		9 AGE (In years last birthday) yrs 51	
10b KIND OF BUSINESS OR INDUSTRY Farmer		11 BIRTHPLACE (County & State or foreign country) Maryland	
13 FATHER'S NAME WALTER HUDSON		12 CITIZEN OF WHAT COUNTRY? USA	
14 MOTHER'S MAIDEN NAME EVERYNN TURNER		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO 214-34-7239		17 INFORMANT Records, Mount Wilson State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung with 165X DUE TO multiple metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2.21.1967 to 5.10.1967 that (I) (we) last saw the deceased alive on 5.10.1967 , and that death occurred at 4:20M , from causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED 5.10.1967	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/13/67	
23c. NAME OF CEMETERY OR CREMATORY I.G.C.F.		23d. LOCATION (City or Town) (County) (State) Bishopville Worcester, Md.	
24. FUNERAL DIRECTOR John H. Haly Selbyville Del.		25a. REC'D BY REGISTRAR MAY 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06311

CERTIFICATE OF DEATH

06301

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Overlea</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7208 Linden Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>7208 Linden Avenue</u>		3. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF (Type or print) First <u>SALLIE</u> Middle <u>F.</u> Last <u>HYMAN</u>		4. DATE OF DEATH Month <u>5</u> Day <u>22</u> Year <u>19 67</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>N.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1-25-1899</u>		9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (County & State or foreign country) <u>WINDSOR, NORTH CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Soloman</u>		14. MOTHER'S MAIDEN NAME <u>SALLIE SIMMONS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT <u>Mrs. Mable Williams</u> Address <u>7208 Linden Avenue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Carcinoma of Cervix</u> DUE TO (c) <u>5 yrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>0</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Balt</u>		20g. (County) <u>Balt</u>		20h. (State) <u>Md</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 19 67</u> to <u>May 21 19 67</u> that (I) (we) last saw the deceased alive on <u>May 21 19 67</u> and that death occurred <u>May 22 19 67</u> at <u>11 A.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>G.M. BAUMGARDNER</u> M.D.		22b. DATE SIGNED <u>5/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G.M. BAUMGARDNER</u>		22d. ADDRESS <u>Balt 2120 6</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-25-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>	
23d. LOCATION (City, town or county) <u>Balt</u>		23e. (State) <u>Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Morton Dyett F.H.</u>		24b. ADDRESS <u>1701 Laurens St</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
25a. DATE <u>MAY 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

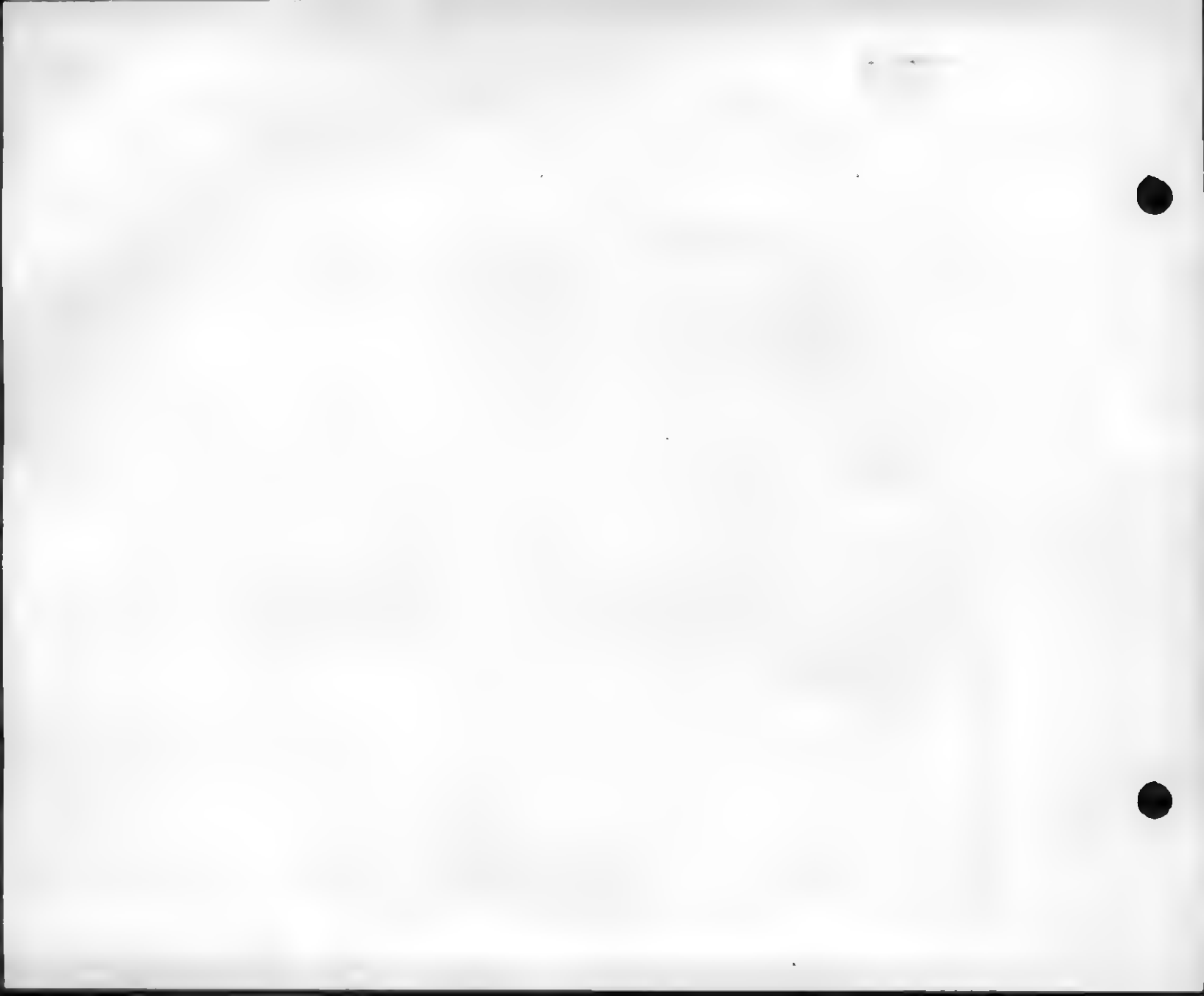
MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06312

CERTIFICATE OF DEATH

06202

1 PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN 1b 6 months.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS 1301 W. Pratt St.	
3 NAME OF DECEASED (Type or print) First Middle Last FRANK GREEN JACOBS		4 DATE OF DEATH Month Day Year 5 / 4 / 19 67	
5 SEX M.	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/25/05
9 AGE (In years last birthday) 61 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer.	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13 FATHER'S NAME Robert Jacobs	
14. MOTHER'S MAIDEN NAME Beverly Anthony		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO 227-07-9331		17. INFORMANT Address Records, Mount Wilson State Hospital	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulm. TB, FA, occlusive. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rt. pleural effusion, TB. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Alcoholism		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/5/66 , to 5/4/1967 , that (I) (we) last saw the deceased alive on 5/4/1967 , and that death occurred 3:20 P.M. from causes and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 5/4/67.	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 5-7-67	23c. NAME OF CEMETERY OR CREMATORY Peaverdam Ch Cert	23d LOCATION (City or Town) (County) (State) Goodview, Va
24 FUNERAL DIRECTOR Harold General Home, P.O. Box 8-111		25a REC'D BY REGISTRAR MAY 9 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06313

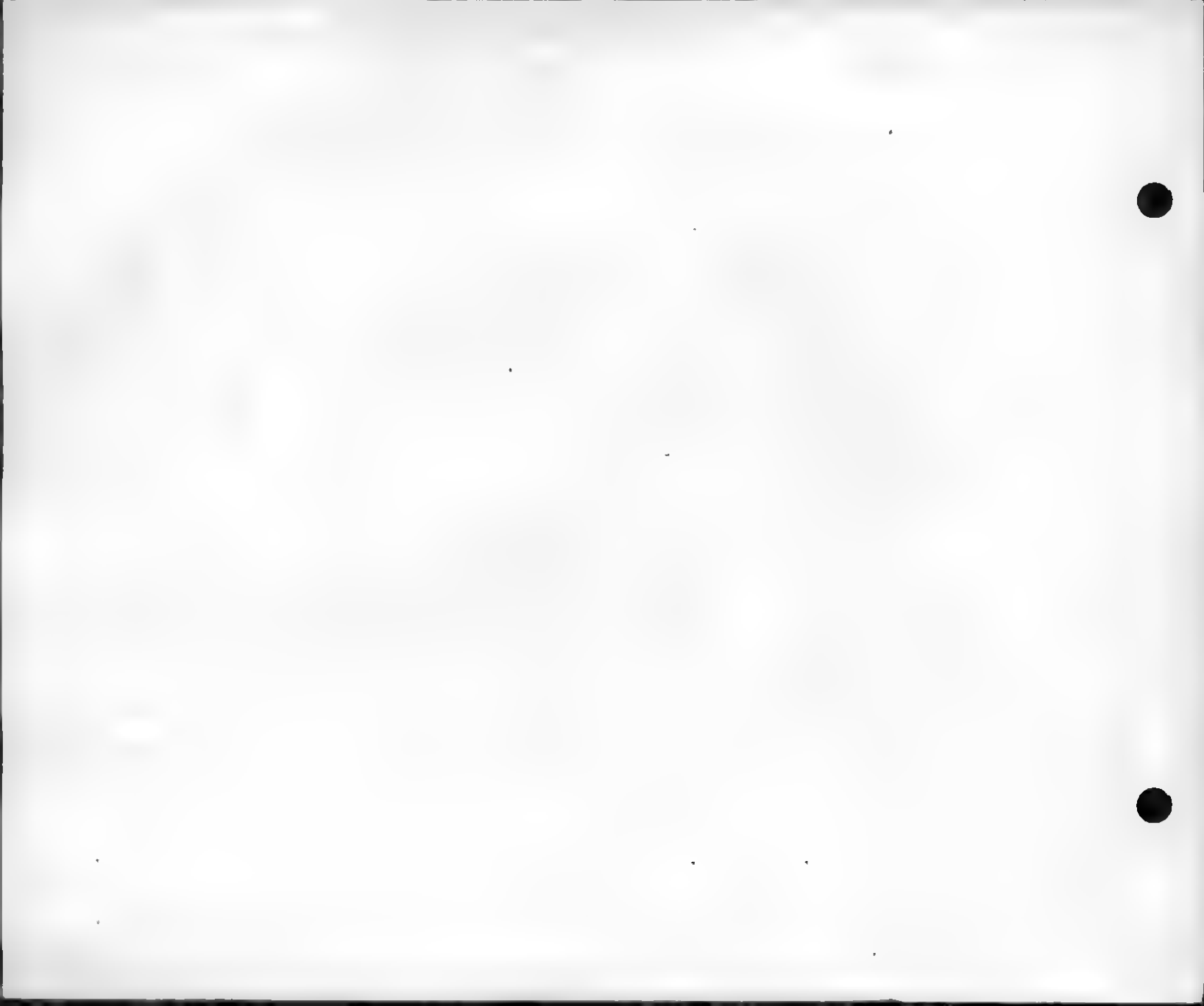
CERTIFICATE OF DEATH

06303

1. PLACE OF DEATH a. COUNTY Baltimore <div style="text-align: right; font-size: small;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md., 21206 b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7911 Elmhurst Ave.		d. STREET ADDRESS 7911 Elmhurst Ave.	
3. NAME OF DECEASED (Type or print) First RICHARD Middle WILSON Last JACOBS		4. DATE OF DEATH Month May Day 21 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/25/12
9. AGE (In years last birthday) 54 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Fisher Body Co.	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard J. Jacobs		14. MOTHER'S MAIDEN NAME Mary S. Propst	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-03-4514	
17. INFORMANT Mary S. Propst, mother, above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 100X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA PHARYNX DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH 6 months			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 5, 1966 , to May 21, 1967 , that (I) (we) last saw the deceased alive on May 19, 1967 , and that death occurred at 1:00 AM , from causes and on the date stated above.			
22a. SIGNATURE Dr. John B. Littleton		22b. DATE SIGNED May 22, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. John B. Littleton		22d. ADDRESS 1012 Old North Point Rd.	
23a. BURIAL CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 5/25/67	
23c. NAME OF CEMETERY OR CREMATORY Sangersville Cemetery		23d. LOCATION (City or town) (County) (State) Sangersville, Va.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		25a. REC'D BY REGISTRAR MAY 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

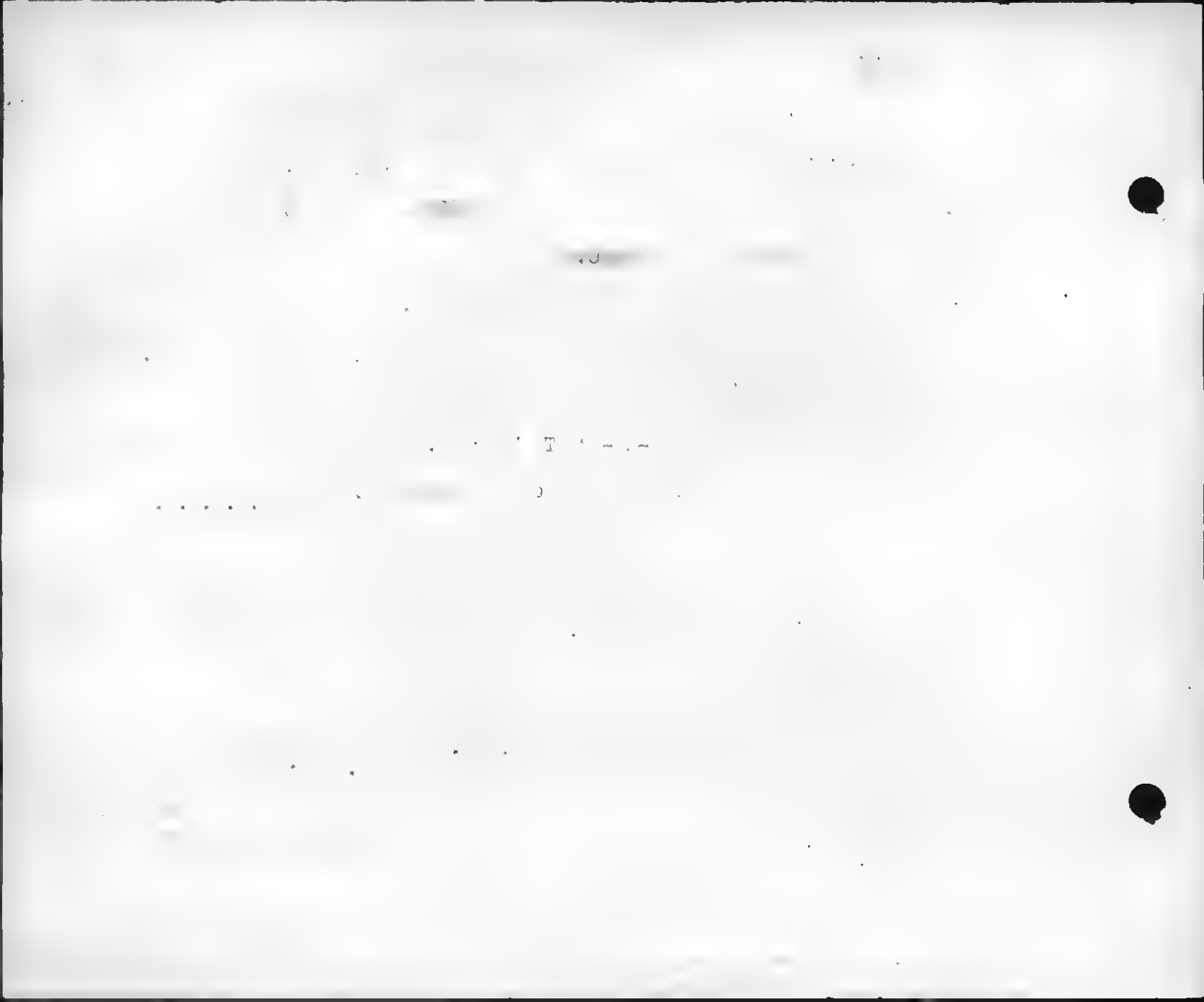


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~these~~ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06314 CERTIFICATE OF DEATH 08204

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN ID 22yr6mth15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 5220 Overcrest Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Loretta C. First C. Last James		4. DATE OF DEATH Month May Day 19 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1891
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Bezold		14. MOTHER'S MAIDEN NAME Theresa Peters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. 220-46-0264	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured aortic aneurysm due to generalized A.S.C.V.D. DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the Breast.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 16 , 19 44 to May 19 , 1967, that (I) (we) last saw the deceased alive on May 19 , 1967, and that death occurred at 5:10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Vicente M. Ruyro		22b. DATE SIGNED May 20, 1967	
22c. PHYSICIAN'S NAME (Type) Vicente M. Ruyro		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/23/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Wm. J. Tuckman & Sons		25a. REC'D BY REGISTRAR 23 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 8

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06315

06305

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		2 USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1, Cockeysville, 21030	
c. LENGTH OF STAY IN 1b 3 days		d. STREET ADDRESS Box 355, Happy Hollow Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First William Middle Lamont Last JAMES		4 DATE OF DEATH Month May Day 16 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 14, 1912
9 AGE (In years last birthday) 54		10 UNDER 1 YEAR Months 5 Days 14 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Oxygen	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David James		14. MOTHER'S MAIDEN NAME Annie Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO 166-09-9411	
17. INFORMANT: wife Mary F. James, Cockeysville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, left hemisphere DUE TO (b) Hypertension DUE TO (c) Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from May 13 , 19 67 , to May 16 , 19 67 not (X) (we) lost saw the deceased alive on May 16 , 19 67 , and that death occurred at 2:10 PM , from causes and on the date stated above.			
22a. SIGNATURE Manuel Cockburn, M.D.		22b. DATE SIGNED May 16, 1967	
22c. PHYSICIAN'S NAME (Typed) Manuel Cockburn, M.D.		22d. ADDRESS 7600 York Road, Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/19/1967	
23c. NAME OF CEMETERY OR CREMATORY Springhill Cemetery		23d. LOCATION (City or Town) (County) (State) Easton, Maryland	
24. FUNERAL DIRECTOR Stewart & Bowen Co., 108 W. North Av., Balto.		25a. REC'D BY REGISTRAR DATE	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE May 18 1967	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **15206**

1. PLACE OF DEATH COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			c. LENGTH OF STAY IN TB			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 21222			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 Centre Avenue				d. STREET ADDRESS 8 Centre Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAX Middle (NMN) Last JANOWICH				4. DATE OF DEATH Month May Day 18th Year 1967					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 16, 1886		9. AGE (In years last birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landlord				10b. KIND OF BUSINESS OR INDUSTRY Property Mgt.		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (unknown) Janowich				14. MOTHER'S MAIDEN NAME unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218-03-8374A		17. INFORMANT Address Steve Janowich Box 672-Route 15 Baltimore, Md. 21220			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Throat DUE TO 178X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary & Hepatic DUE TO metastases (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.		Month _____ Day _____ Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 5/13 1967 , to 5/18 1967 , that I last saw the deceased alive on 5/17 1967 , and that death occurred at M from the causes and on the date stated above.									
ACTUAL SIGNATURE Theodore C. Patterson M.D.				ADDRESS (Street, city or town, state) 105 Main Street				DATE SIGNED 5/19/67	
PHYSICIAN'S NAME (Type) Theodore C. Patterson, M.D. Baltimore, Maryland 21222									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/20/67		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc. Dundalk 22						24. REC'D BY REGISTRAR MAY 22 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



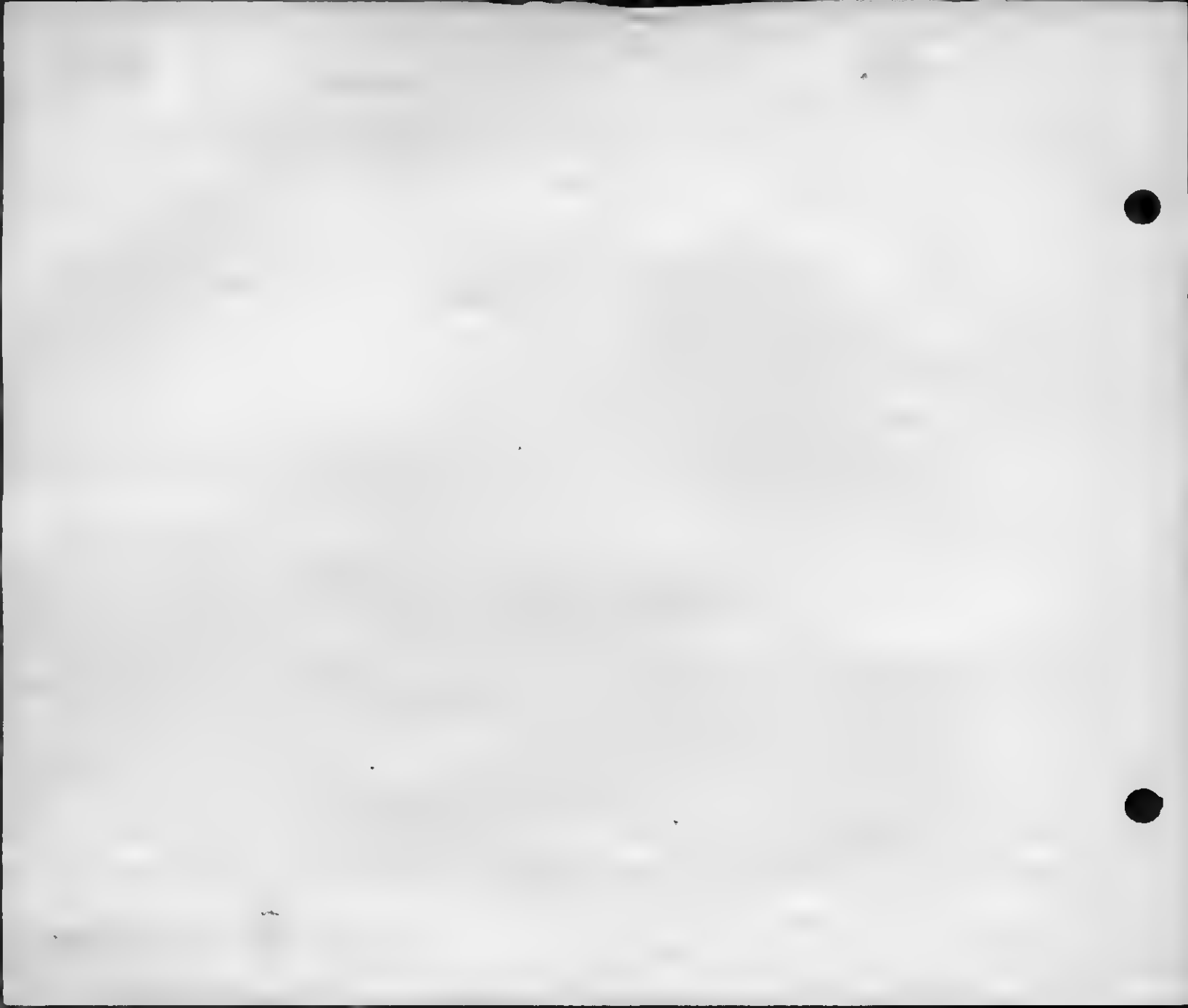
CERTIFICATE OF DEATH

06317

06307

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <u>Elkridge</u>		c. LENGTH OF STAY IN life <u>Life</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5500 -B- Race Road</u>		d. STREET ADDRESS <u>5500 -B- Race Road</u>		<input type="checkbox"/> 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Allen</u> Middle <u>Roberto</u> Last <u>Jarvis</u>		4. DATE OF DEATH <u>May</u> <u>4</u> <u>19</u> <u>67</u>		Month Day Year <input type="checkbox"/> 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October, 11, 1911</u>	9. AGE (in years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Elkridge, Maryland</u>	
13. FATHER'S NAME <u>James Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Flannia A. Robinson</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Allen Jarvis Jr 5500 -B- Race Road</u>		17. INFORMANT <u>Mr. Allen Jarvis Jr 5500 -B- Race Road</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cirrhosis of liver</u> <u>581.0</u> DUE TO <u>a splenic hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Cardio Vascular disease</u> (c) <u>most</u>					INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 1, 1967</u> , to <u>May 4, 1967</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>May 4, 1967</u> , and that death occurred at <u>8:03 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>B B Brumbaugh M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>B B Brumbaugh MD</u>		22d. ADDRESS <u>5609 Main St Elkridge Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>5/8/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>	
23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert A. Wotton</u>		ADDRESS <u>3035 W. Pratt Ave Baltimore, Md</u>		25a. REC'D BY REGISTRAR <u>MAY 8 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06308

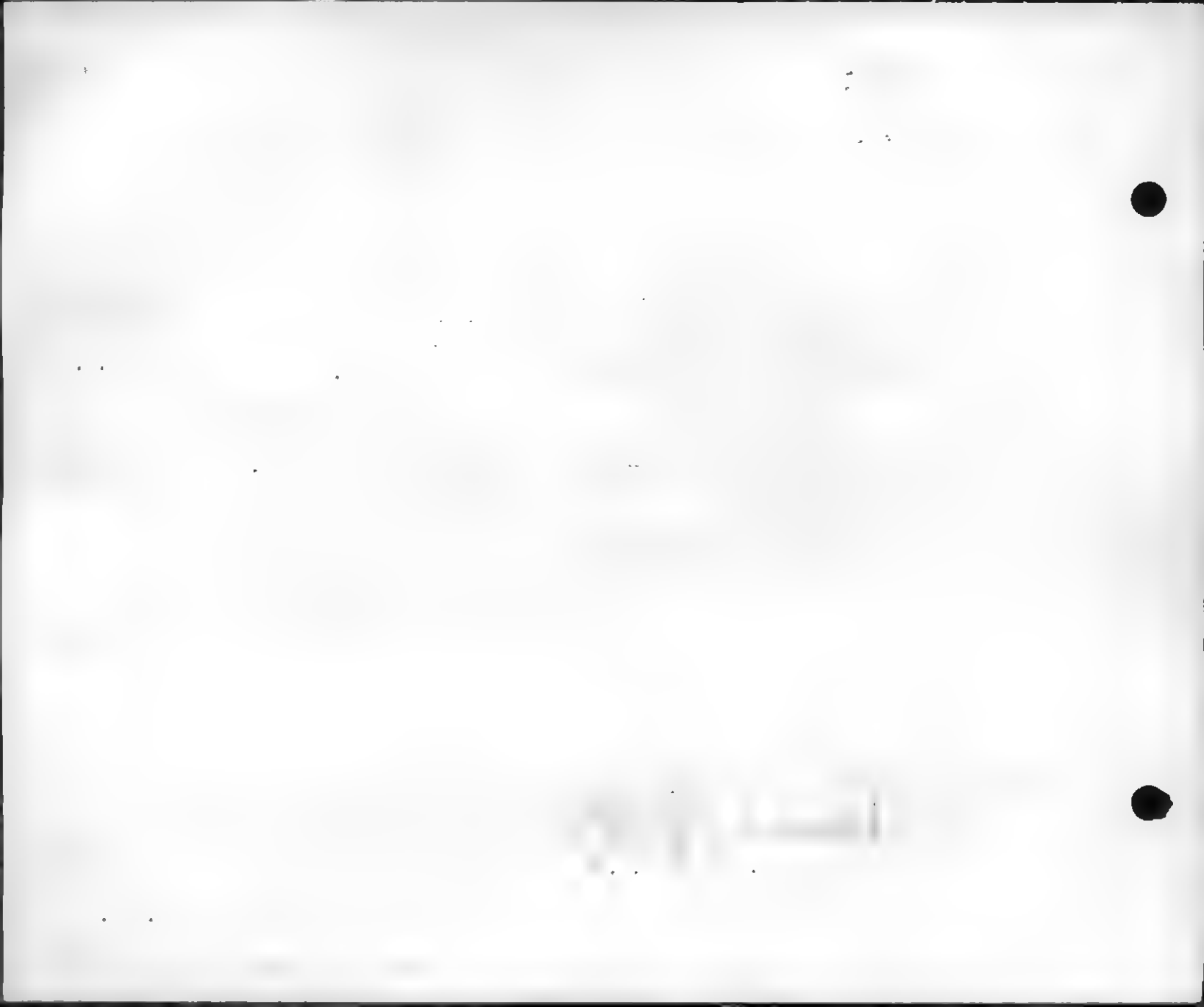
FOR STATE HEALTH DEPT.

06318

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton				c. LENGTH OF STAY IN TB yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 525 Old Home Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROLAND Middle LEE Last JONES				4. DATE OF DEATH Month 5 Day 9 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-3-1905	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months 5 Days 9		IF UNDER 24 HRS Hours 19 Min 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aircraft		10b. KIND OF BUSINESS OR INDUSTRY Boeing Aircraft		11. BIRTHPLACE (State or foreign country) Denton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Jones				14. MOTHER'S MAIDEN NAME Carrie Anthony			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-12-2416		17. INFORMANT Mrs Clara Figgs 1503 W. 36th Street			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver 10 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> Partial	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month Day, Year Hour 19 m pm		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Partial		20f. (City or town, County, State) Partial	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5-9-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-12-1967		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.	
24. FUNERAL DIRECTOR Leslie Funeral Home 2401 B. Ave Road				25a. REC'D BY REGISTRAR MAY 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #6 Film #G: 8-11-1967

06313

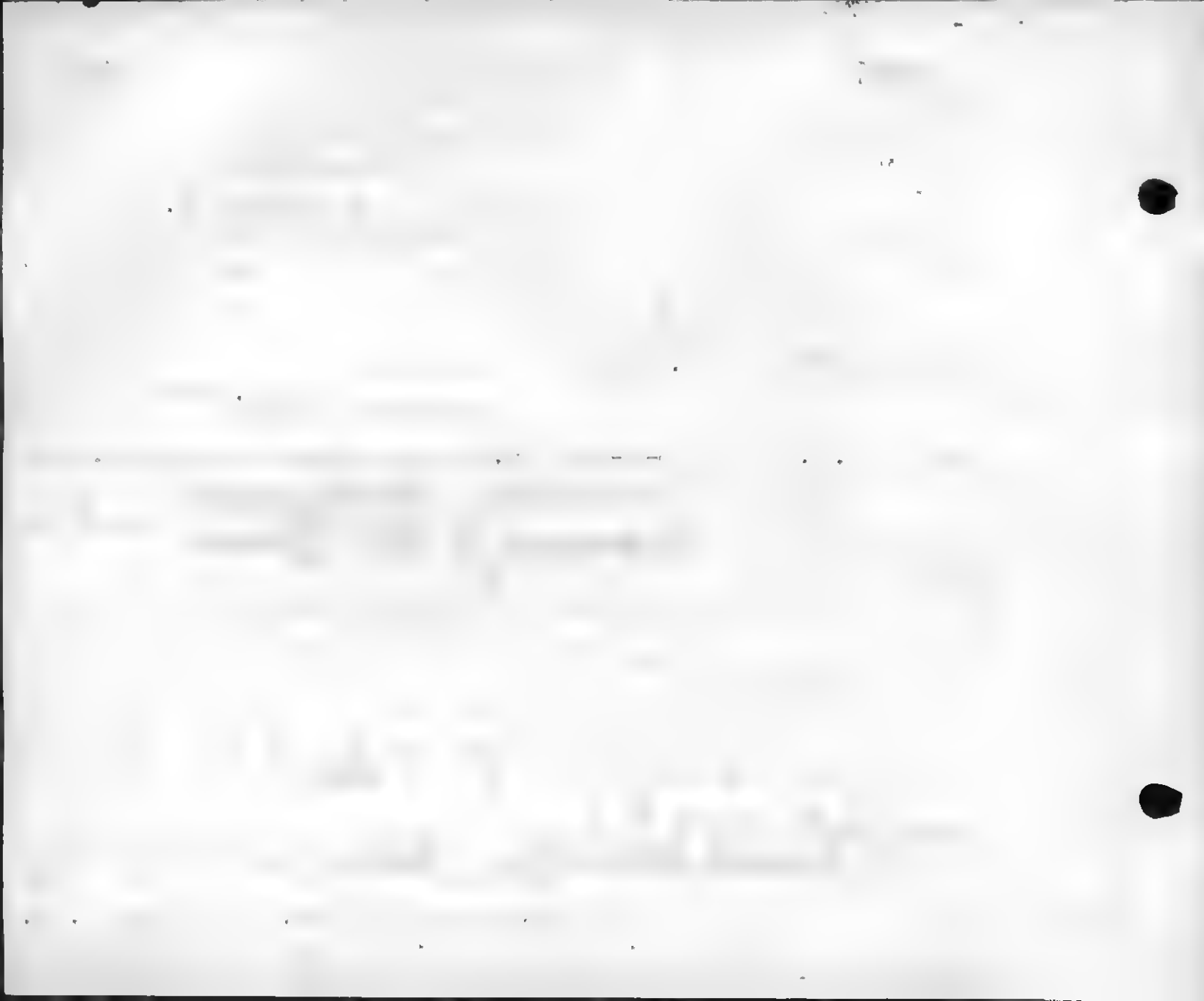
CERTIFICATE OF DEATH

1967

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21207</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hospital</u>		d. STREET ADDRESS <u>4104 Buckingham Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>B.</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-8-24</u>
9. AGE (In years last birthday) <u>42</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Office</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ft. Holobird</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas B. Jones sr.</u>		14. MOTHER'S MAIDEN NAME <u>Sarah A. Crabill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes W.W. II</u>		16. SOCIAL SECURITY NO. <u>225-28-0442</u>	
17. INFORMANT <u>Mrs. Deborah Jones-4104 Buckingham Rd. 21207</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1930</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Melanoma of the Brain</u> (c) <u>Melanotic Malignant</u>		INTERVAL BETWEEN ONSET AND DEATH <u>undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-19, 1967</u> to <u>5-12, 1967</u> that (I) (we) last saw the deceased alive on <u>5-12, 1967</u> and that death occurred at <u>8:30 AM</u> , from causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <u>RUPERTO MANANKIL</u>		22c. PHYSICIAN'S NAME (Type) <u>RUPERTO MANANKIL</u>	
22d. ADDRESS <u>Baltimore County Gen. Hosp.</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/15/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Wash. Blvd & Dorsey Rd. Md.</u>
24. FUNERAL DIRECTOR <u>Loring Byers</u>		25a. REC'D BY REGISTRAR <u>MAY 15 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach both papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06320

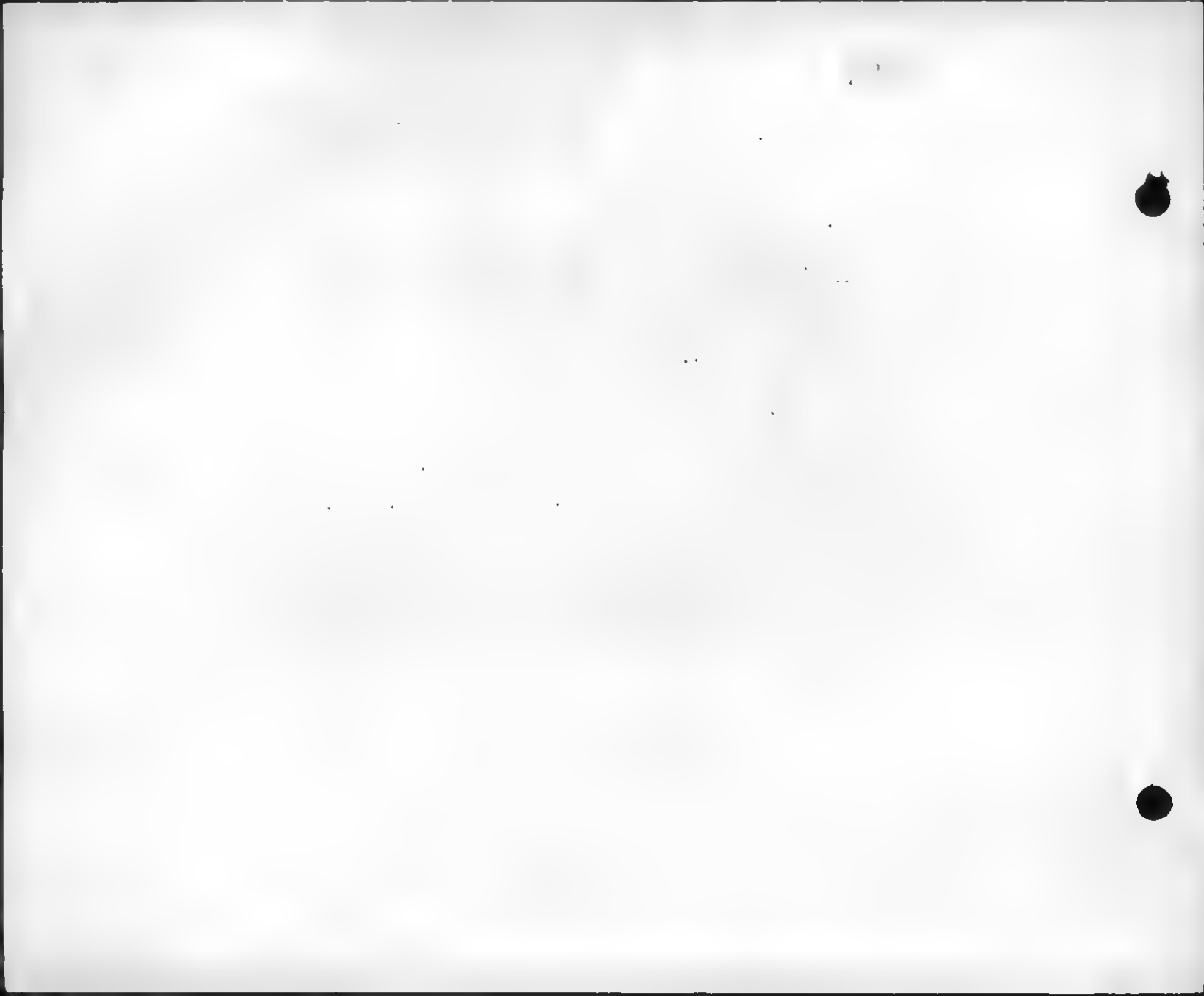
CERTIFICATE OF DEATH

06310

1 PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Md. c. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN b 17 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS 833 W. Lombard St.	
3 NAME OF DECEASED (Type or print) First ARNOLD Middle Miller Last JUSTICE		4 DATE OF DEATH Month MAY Day 7 Year 19 67	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-17-12
9 AGE (In years last birthday) 54 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	
10b. KIND OF BUSINESS OR INDUSTRY Box Factory		11 BIRTHPLACE (County & State, or foreign country) Md.	
12 CITIZEN OF WHAT COUNTRY? U.S.G.		13 FATHER'S NAME William Justice	
14 MOTHER'S MAIDEN NAME EMMA RUBENCOY		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16 SOCIAL SECURITY NO 215-10-0916		17. INFORMANT Records, Mount Wilson State Hospital	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4244 Congestive heart failure DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Pulmonary tuberculosis - ASTHMA		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/11/67	
23c. NAME OF CEMETERY OR CREMATORY Landon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker, Sts		25a. REC'D BY REGISTRAR MAY 10 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

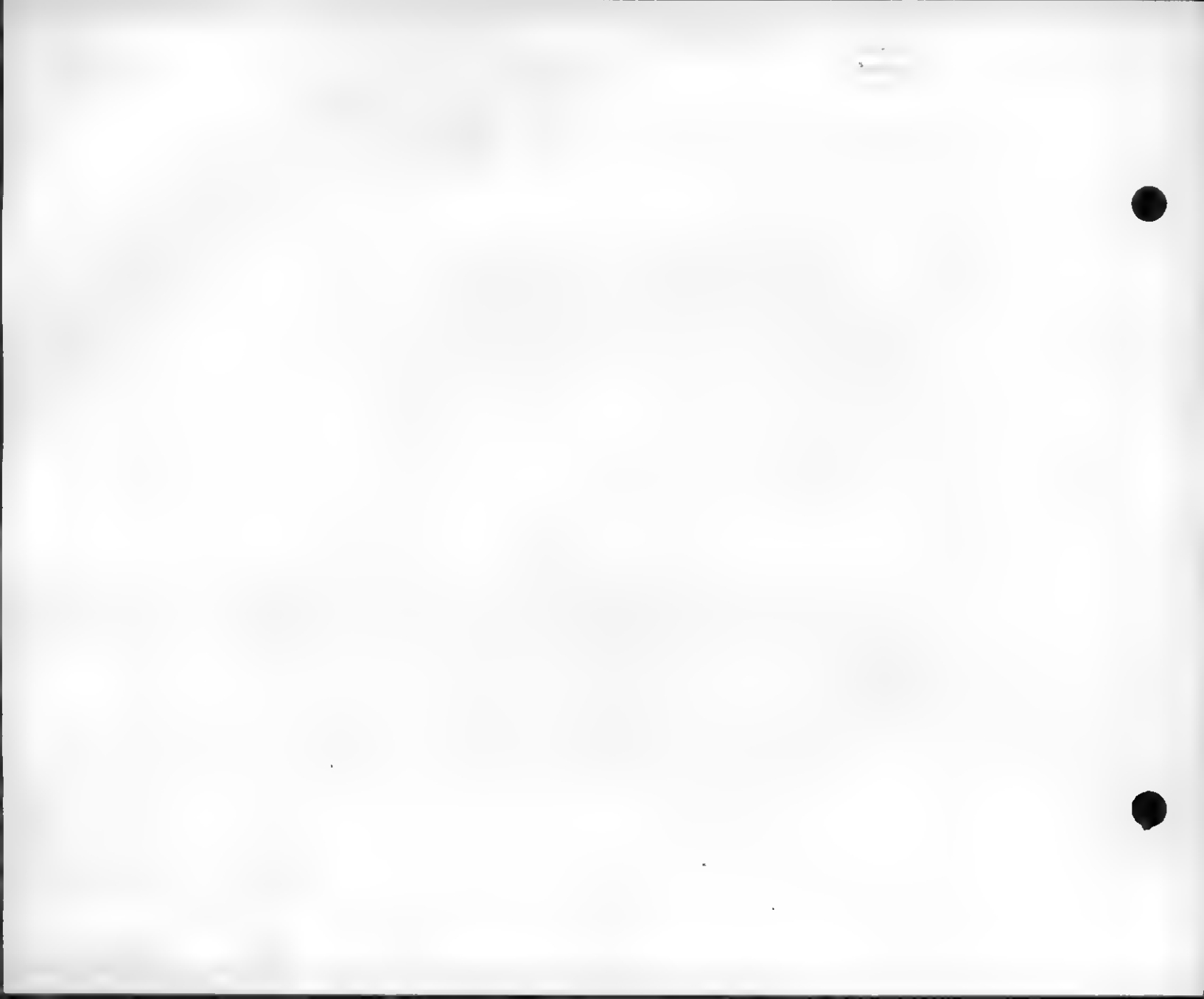
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06321

CERTIFICATE OF DEATH

06311

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore 21212 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212 d. STREET ADDRESS 626 Glenwood Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Mary Middle D Last KANE				4 DATE OF DEATH Month May Day 6 Year 19 67			
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8 DATE OF BIRTH September 3, 1914	
9 AGE (In years last birthday) 52 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME George Dittrich		14 MOTHER'S MAIDEN NAME Anna M. Durrbeck		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO 215-10-4942		17. INFORMANT Family Records		18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma DUE TO (b) Portal cirrhosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I (this hospital) attended the deceased from March 18, 19 67 , to May 6, 19 67 , that I (we) last saw the deceased alive on May 6, 19 67 , and that death occurred at 1:25PM , from causes and on the date stated above.							
22a SIGNATURE Reynaldo Orjuela-Gomez				22b. DATE SIGNED May 6, 1967		22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez	
22d ADDRESS 7620 York Rd., Towson, Md. 21204				22e. DATE SIGNED May 6, 1967		22f. REGISTRAR'S SIGNATURE Charles Yuage	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 5/10/67		23c NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM		23d LOCATION (City or Town) (County) (State) BALTIMORE MD	
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road				25a. REC'D BY REGISTRAR MAY 9 1967		25b. REGISTRAR'S SIGNATURE Charles Yuage	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

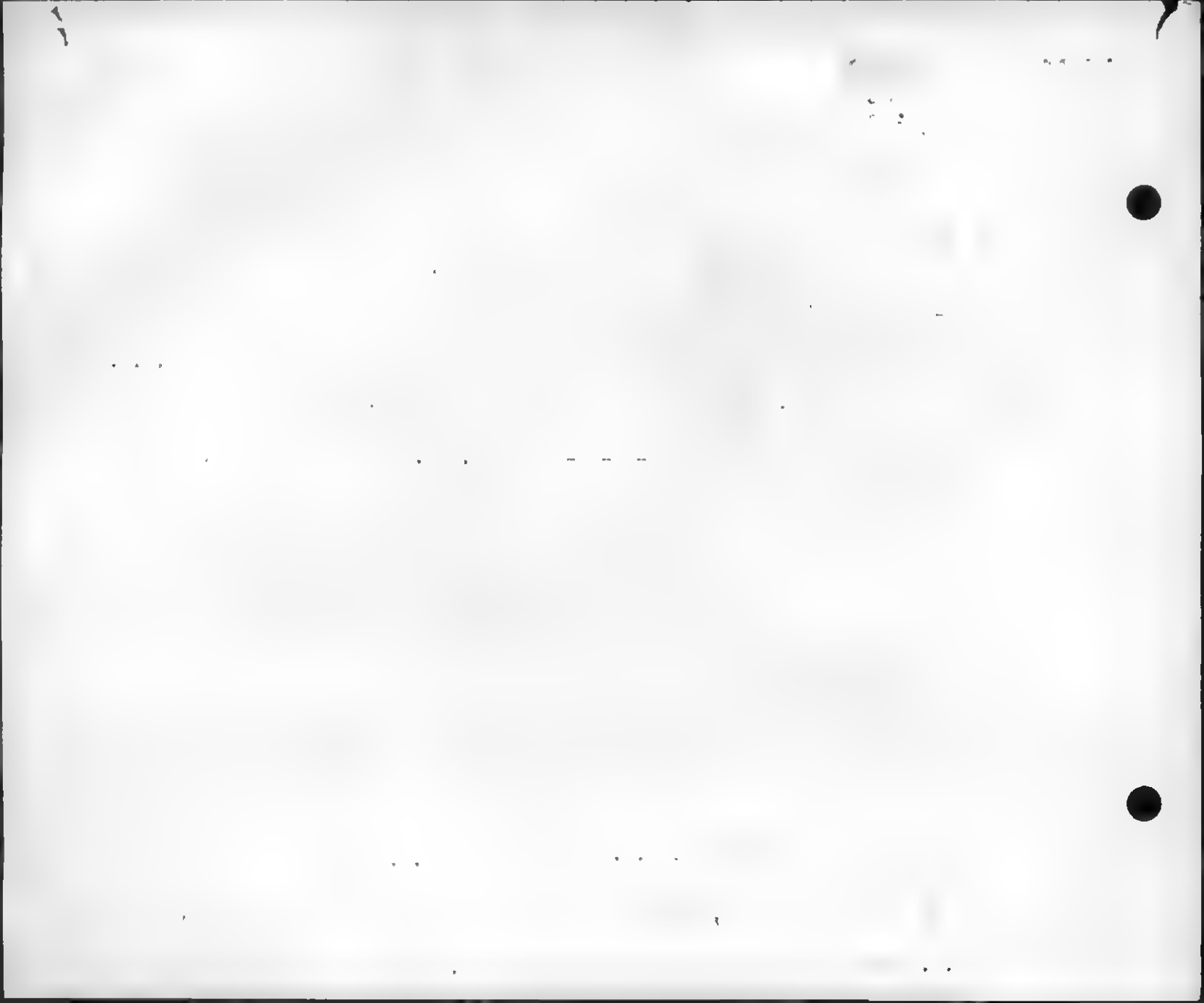
06322

CERTIFICATE OF DEATH

06312

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 9 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt 1, Box 34B Millersville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS Dogwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BERNARD GOODMAN KEIRSEY SR.				4. DATE OF DEATH Month Day Year MAY 24 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/1896		9. AGE (in years last birthday) 70 YRS	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Hanger		10b. KIND OF BUSINESS OR INDUSTRY Paper Hanging		11. BIRTHPLACE (County & State, or foreign country) Petersburg, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter H. Keirsey				14. MOTHER'S MAIDEN NAME Mary E. Lucienberg			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 215-22-74-88		17. INFORMANT Address Clin. Rec. VAH, Fort Howard, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO (b) THROMBOSIS OF ARTERIOSCLEROTIC CORONARY ARTERY DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH SECONDS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from <u>May 15</u> , 1967, to <u>May 24</u> , 1967, that he (we) last saw the deceased alive on <u>May 24</u> , 1967, and that death occurred at <u>6:00PM</u> from causes and on the date stated above.							
22a. SIGNATURE <i>Alfonso Lopez</i> ALFONSO LOPEZ, M.D.				22b. DATE SIGNED 5/24/67		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS V.A. HOSPITAL, FORT HOWARD, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 29, 1967		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCAT ON (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR R. V. SINGLETON FUNERAL HOME GLEN BURNIE, MD.				25a. REC'D BY REGISTRAR MAY 26 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tarban papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

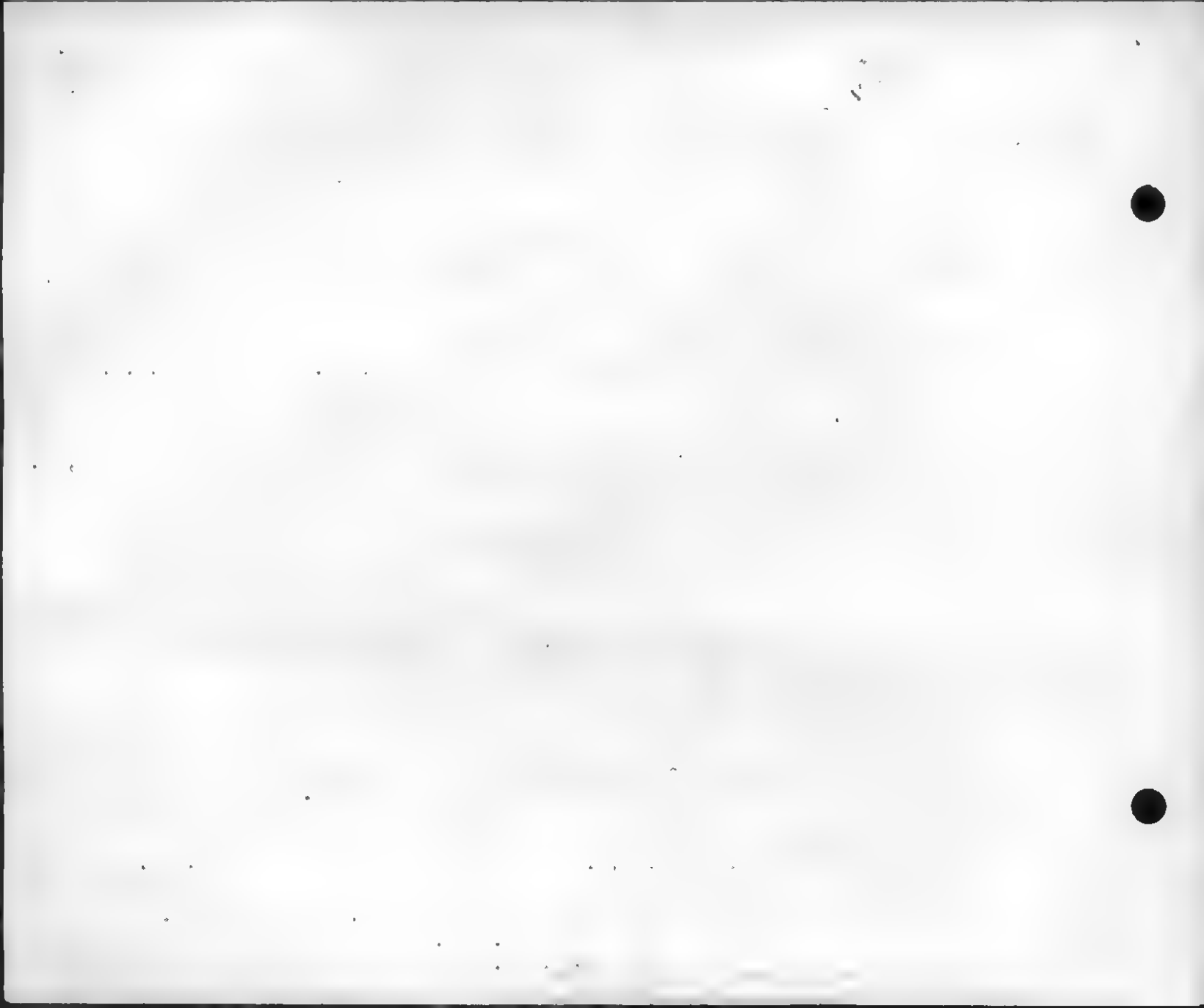
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06323

CERTIFICATE OF DEATH

06313

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 17	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 2255 Reisterstown Road	
3. NAME OF DECEASED (Type or print) CHARLES BROWN KELLER		4. DATE OF DEATH Month May Day 13 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/28/94
9. AGE (in years last birthday) yrs 72		10. IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Monotype Operator		10b. KIND OF BUSINESS OR INDUSTRY Newspapers	
11. BIRTHPLACE (County & State, or foreign country) Littleton, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles B. Keller		14. MOTHER'S MAIDEN NAME Lucinda King	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO. 217 09 42 79	
17. INFORMANT Clinical Rcds VA Hospital, Fort Howard, Md.		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO (b) CARCINOMA OF ESOPHAGUS (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Days Years	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic vascular Heart Disease-Congestive Heart Failure			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 4 , 1967, to May 13 , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 13 , 1967, and that death occurred at 1:20 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Afonso A. Lopez</i>		22b. DATE SIGNED 5/13/67	
22c. PHYSICIAN'S NAME (Type) ALFONSO A. LOPEZ, M.D.		22d. ADDRESS VA Hospital, Fort Howard, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/17/1967	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City or town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR <i>Wm. J. Tickner & Sons</i> Tickner Funeral Home		25a. REC'D BY REGISTRAR DATE MAY 16 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			



7 1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06324

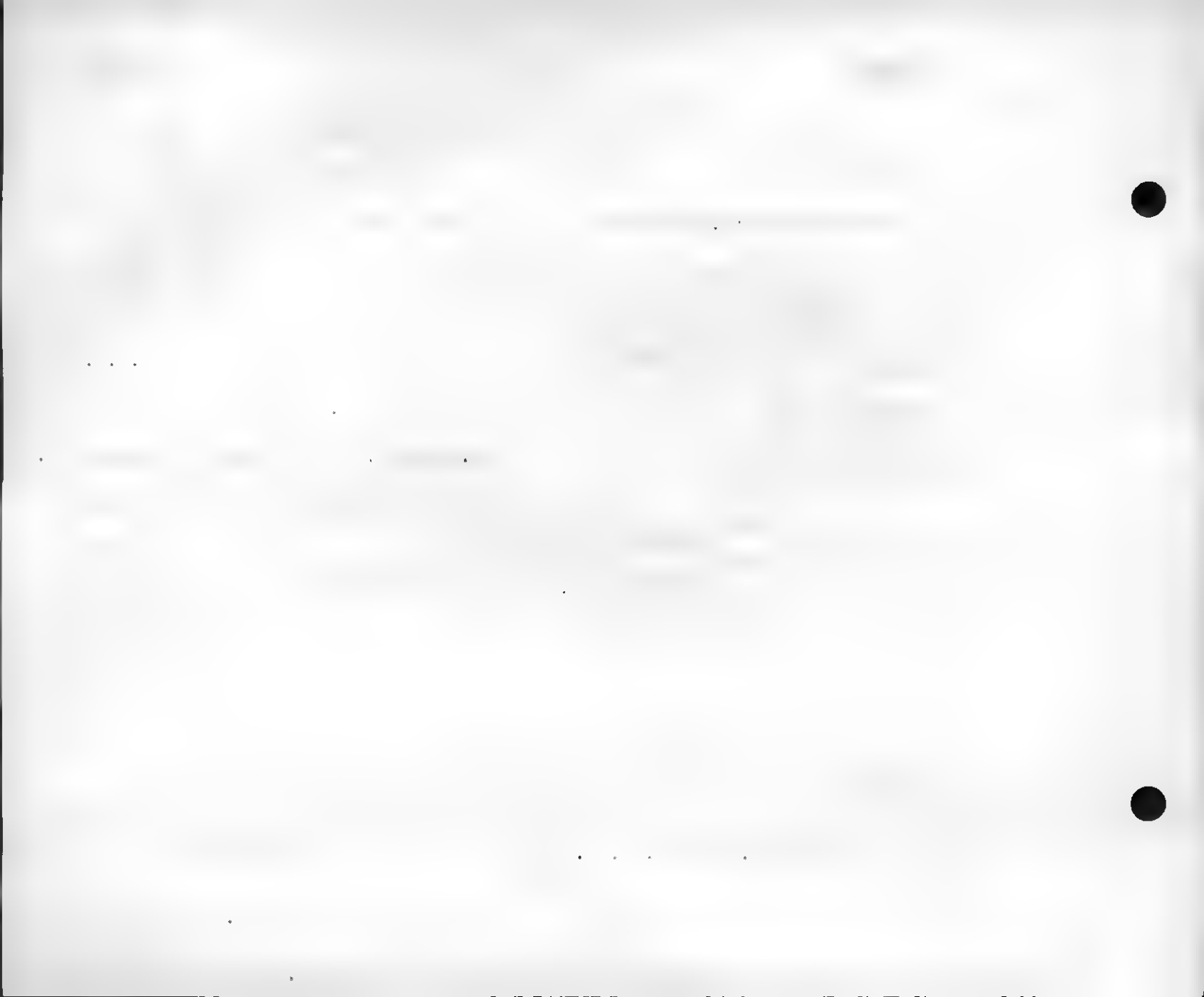
CERTIFICATE OF DEATH

06314

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITE MARSH		
c. LENGTH OF STAY IN b 78 DAYS					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			d. STREET ADDRESS BOX 1071B		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3 NAME OF DECEASED (Type or print) First HARRY Middle C. Last KELLNER			4 DATE OF DEATH Month MAY Day 26 Year 19 67		
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/30/95		9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10b. KIND OF BUSINESS OR INDUSTRY PLUMBING SHOP	11 BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME OSCAR KELLNER			14. MOTHER'S MAIDEN NAME MINNIE MN: UNKNOWN		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16 SOCIAL SECURITY NO. 215 10 66 85	17 INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PAPILLARY NECROSIS KIDNEYS, BILATERAL (b) PULMONARY EDEMA (c) ARTERIOSCLEROTIC HEART DISEASE					INTERVAL BETWEEN ONSET AND DEATH UNKNOWN RECENT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS, CLINICAL					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town)	(County)	(State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/9/67 , 19 67 , to 5/26/67 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/26/67 , 19 67 , and that death occurred at 6:15 AM , from causes and on the date stated above.					
22a. SIGNATURE <i>Jorge A. Fabara</i>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/26/67
22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D.			22d. ADDRESS VAH FORT HOWARD, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-29-67	23c. NAME OF CEMETERY OR CREMATORY CAMP CHAPEL CEMETERY	23d. LOCATION (City or Town) (County) (State) JOPPA RD. PERRY HALL, MD.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR Charles Judge DATE MAY 29 1967 25b. REGISTRAR'S SIGNATURE		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Items #2c & d file 6/2/67

06325

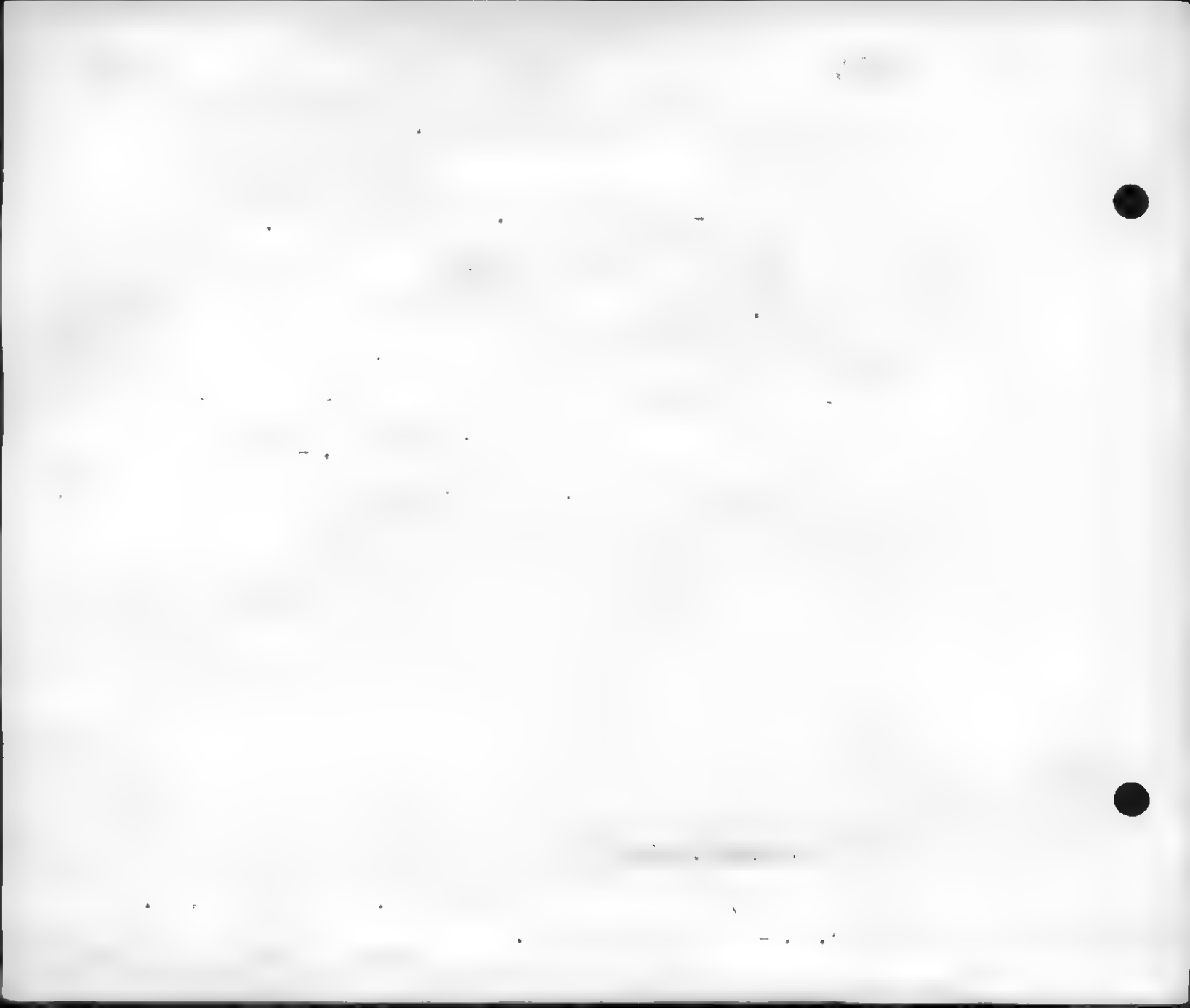
CERTIFICATE OF DEATH

06315

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, Balto. 21229	
3. NAME OF DECEASED (Type or print) First Anna Middle Marie Last Kelly		4. DATE OF DEATH Month May Day 18 Year 19 67	
5. SEX F	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/20/88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State or foreign country) New Jersey	
13. FATHER'S NAME Late - Joseph McCurnin		14. MOTHER'S MAIDEN NAME Late - Mary ---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. INFORMANT Mrs. Marie Kelly Snyder Address 609 Stamford Rd. - 21229	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis with Chronic Brain Syndrome 444x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Essential Hypertension			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from Oct. , 19 51 , to May , 19 67 , that (I) (we) last saw the deceased alive on May 16 , 19 67 , and that death occurred at 6:10 PM , from causes and on the date stated above			
22a. SIGNATURE Leo J. Gaver M.D.		22b. DATE SIGNED May 19, 1967	
22c. PHYSICIAN'S NAME (Type) Leo J. Gaver, M.D.		22d. ADDRESS 1 Mallow Hill Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/22/67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	23d. LOCATION (City or town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR DATE MAY 22 1967	25b. REGISTRAR'S SIGNATURE Thomas Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

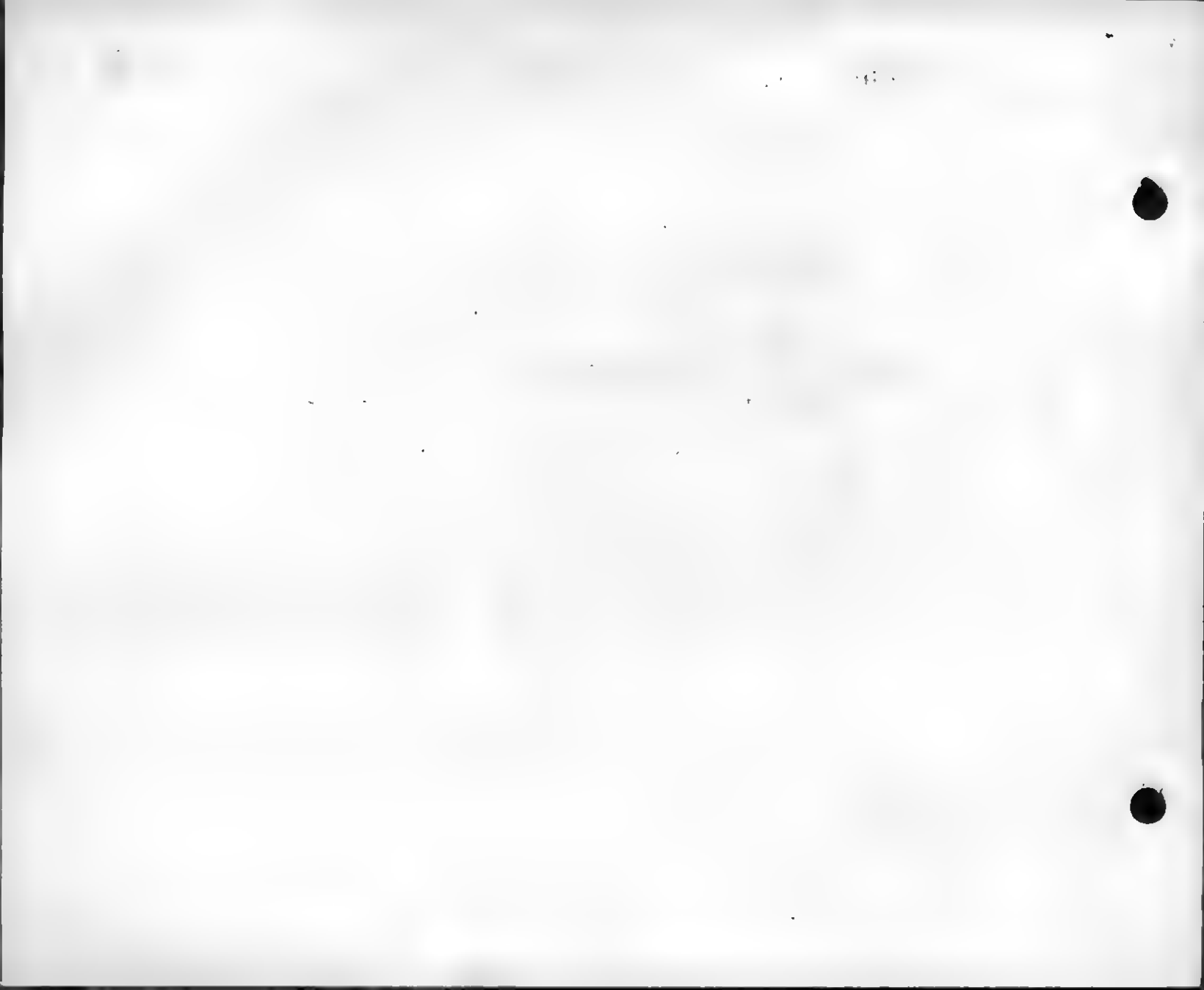
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06326

It is 3:11 PM 5/26/67 kkk

06316

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c. LENGTH OF STAY IN 1b 50 yr.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3009 6th Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HOWARD E KEMMERLY Kemmerly				4. DATE OF DEATH Month Day Year May 22 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15 1885		9. AGE (in years last birthday) 81 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman			10b. KIND OF BUSINESS OR INDUSTRY Balto Transit		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Lazarus Kemmerly				14. MOTHER'S MAIDEN NAME Esther Ford			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-2995		17. INFORMANT Family Records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerosis CVD e Myocardial Infarction DUE TO (b) Chronic myocardial DUE TO (c) Chronic myocardial Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 3 yrs 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8 AM , 19 67 , to 22 May , 19 67 that (I) (we) last saw the deceased alive on 21 May , 19 67 , and that death occurred at 10 PM , from causes and on the date stated above.							
22a. SIGNATURE Howard Goodman			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 23 May 67		
22c. PHYSICIAN'S NAME (Type) Howard Goodman			22d. ADDRESS 8604 Harford road				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/26/67	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City or town) (County) (State) Balto Md.			
24. FUNERAL DIRECTOR ADDRESS C.F. EVANS & SON 8802 Harford Rd.				25a. REC'D BY REGISTRAR DATE MAY 24 1967		25b. REGISTRAR'S SIGNATURE John J. Judge	



MD 1 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

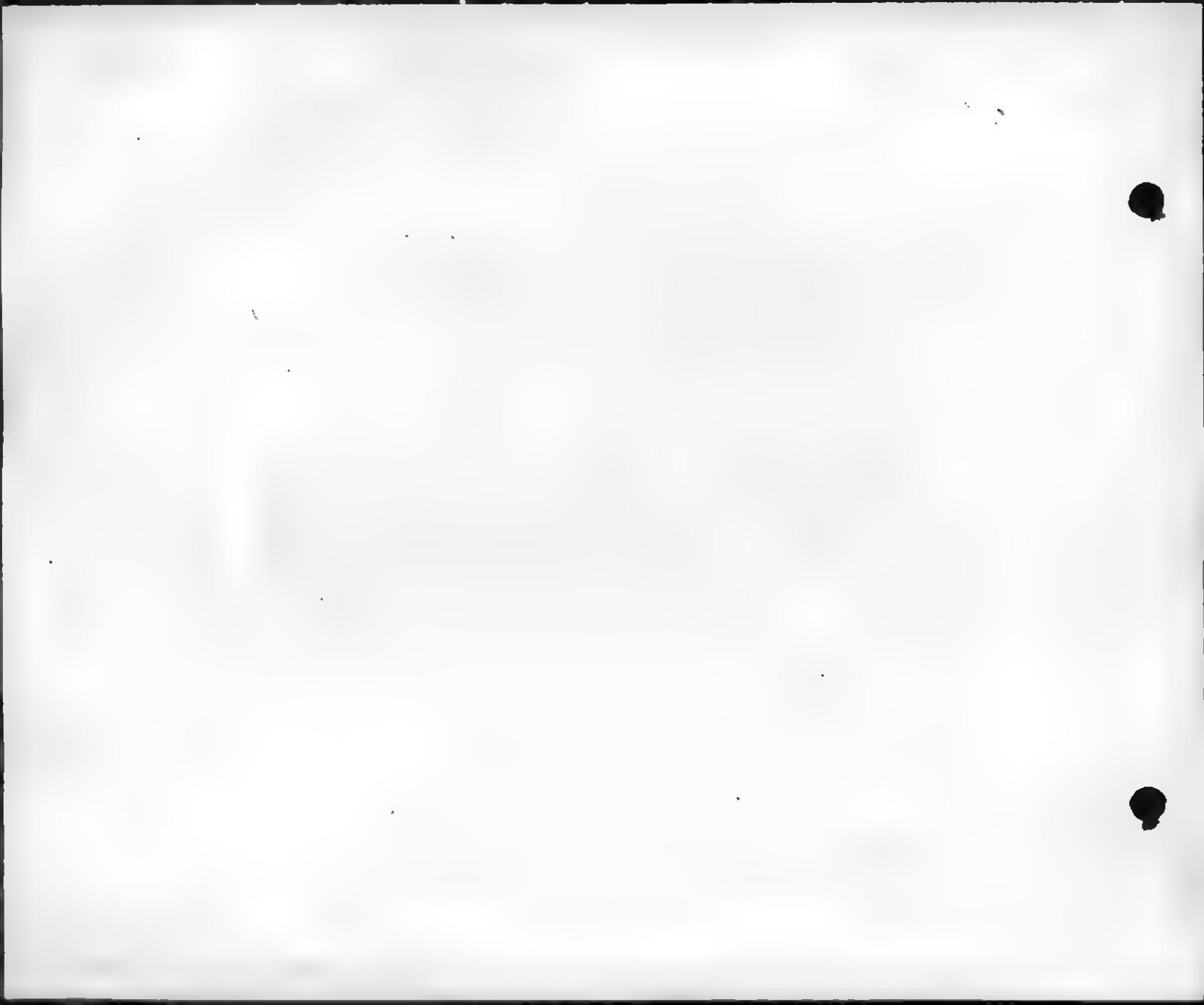
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06327

CERTIFICATE OF DEATH

06317

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fork</u>		c. LENGTH OF STAY IN <u>1b</u> <u>25 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fork MD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 30 Fork RCA D.</u>				d. STREET ADDRESS <u>Box 30 Fork Rd Baldwin</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Kendrick</u> Last <u>Kendrick</u>				4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-1898</u>	9. AGE (In years last birthday) <u>76</u> yrs	10. IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>10</u> Min <u>10</u>		11. IF UNDER 24 HRS Months <u>7</u> Days <u>10</u> Hours <u>10</u> Min <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Peterhawk</u>				14. MOTHER'S MAIDEN NAME <u>Mary Denasco</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Mr George Fay, Box 30 Baldwin Ind</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular</u> <u>334 X</u> DUE TO <u>General Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes mellitus</u> DUE TO (c) <u>Diabetes mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yr.</u> <u>2 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/24</u> , 19 <u>65</u> , to <u>5/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/3</u> , 19 <u>67</u> , and that death occurred at <u>4</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>Clifford F. Hudson</u>				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>				22d. ADDRESS <u>FORK MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-6-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO</u> <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Road</u>				ADDRESS <u>(30)</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 8 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Johnas Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

36328

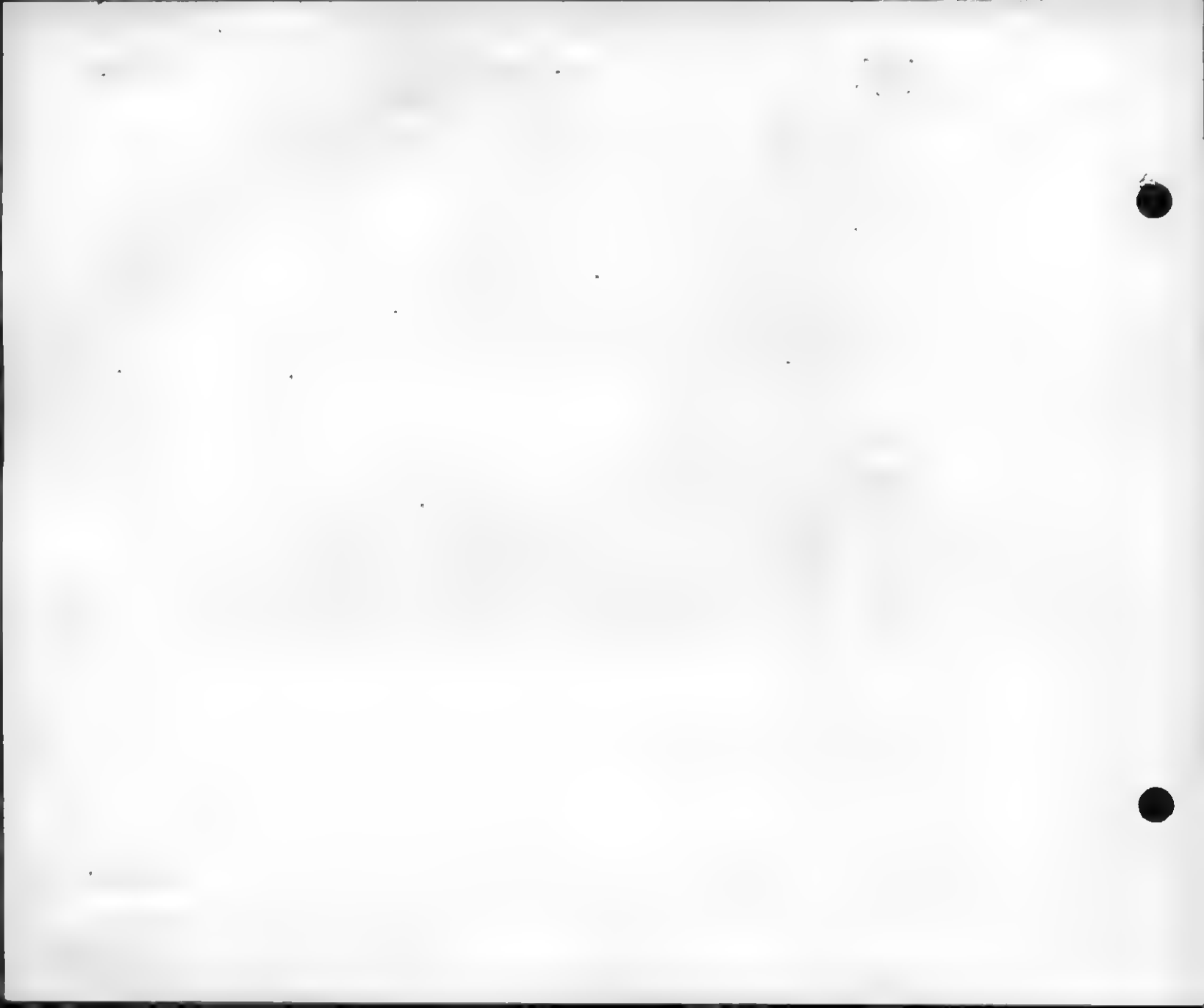
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

36328

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		21221	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 608 N. Woodward Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hilton Middle B. Last King				4. DATE OF DEATH Month May Day 15 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-10	9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months 5 Days 15 Hours 15 Min.		11. IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) receiving dept.		10b. KIND OF BUSINESS OR INDUSTRY Food		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. C. TIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212-09-7523		17. INFORMANT Address 21221 Mrs. Eleanora King, 608 Northwood Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Abdominal Aneurysm DUE TO + Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 15 , 19 67 to May 15 , 19 67 , that (I) (we) last saw the deceased alive on May 15 , 19 67 , and that death occurred on May 15 , 19 67 at 10:58 M, from causes on and on the date stated above.							
22a. SIGNATURE Juan Gan				22b. DATE SIGNED May 15, 1967		22c. PHYSICIAN'S NAME (Type) Juan Gan M.D.	
22d. ADDRESS 7620 York Road - Towson 21204, Md.				22e. ADDRESS			
23a. BURIAL CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 5-18-67		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION (City or Town) (County) (State) Baltimore County, Md.	
24. FUNERAL DIRECTOR Ulrich Funeral Home, Baltimore, Md.				25a. REGISTERED MAY 22 1967		25b. REGISTRAR'S SIGNATURE J. J. Judge	



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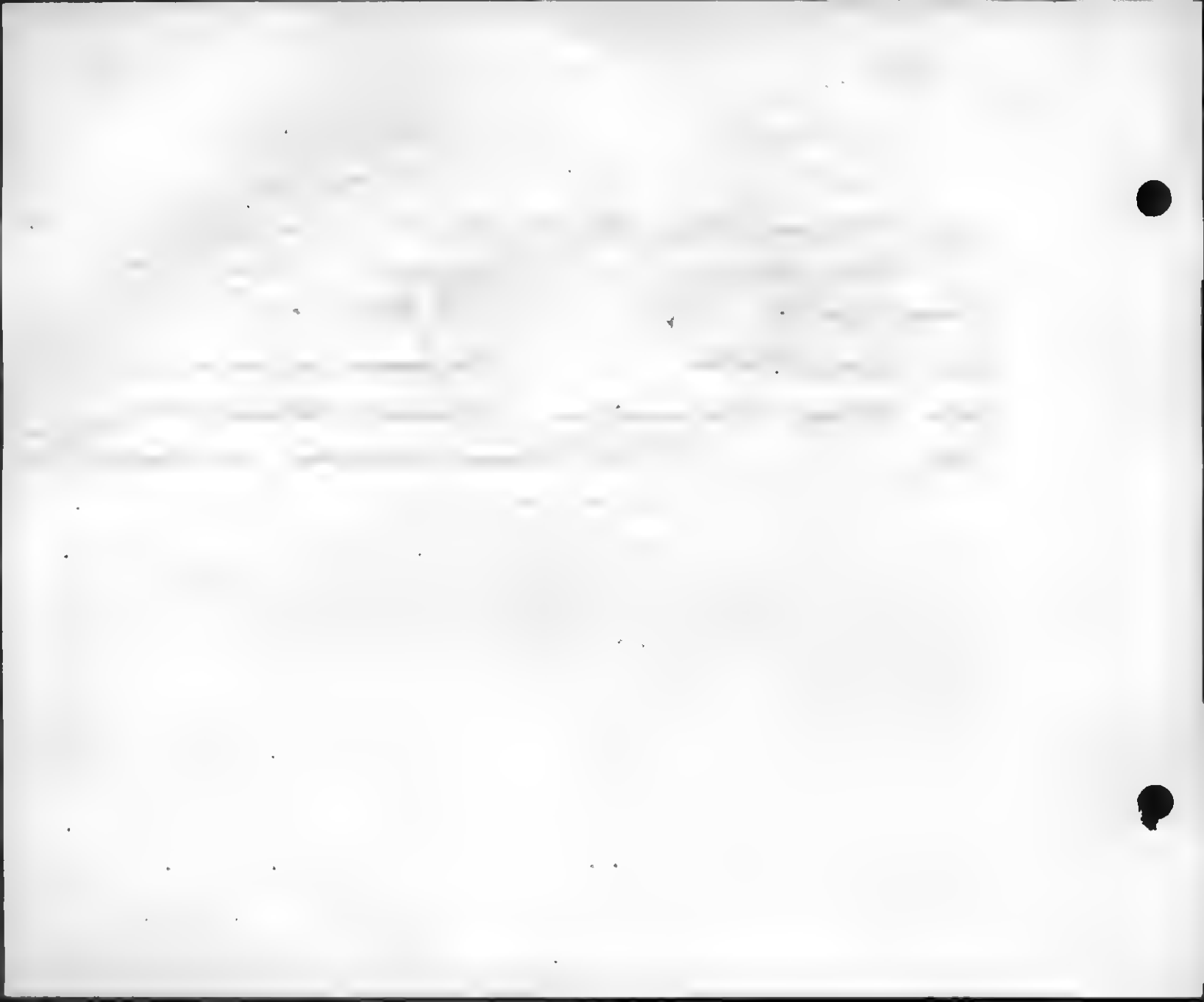
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06323

CERTIFICATE OF DEATH

05219

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Agnes Womans & Menus House</u>	
d. STREET ADDRESS <u>619 E. 33rd Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Mrs. Louise Saunders Kieselberg</u>		4 DATE OF DEATH <u>May 19 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1892</u>
9. AGE (In years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dep't. of Motor Vehicles</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Richmond, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henry Bramberry</u>		14. MOTHER'S MAIDEN NAME <u>Adelaide Gouldman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-18-7793</u>	
17. INFORMANT <u>Larry E. Hamilton</u>		Address <u>615 Chestnut Ave. Towson</u>	
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>4342</u> IMMEDIATE CAUSE (a) <u>Acute cardiac failure (terminal)</u> DUE TO (b) <u>Acute pulmonary edema, bilateral</u> DUE TO (c) <u>Chronic arteriosclerotic, cardio-vascular syndrome</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 MI.</u> <u>1 day.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 14, 1962</u> , to <u>May 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 19, 1967</u> , and that death occurred at <u>4:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edwin B. Jarrett</u>		22b. DATE SIGNED <u>5/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edwin B. Jarrett, M.D.</u>		22d. ADDRESS <u>11 East Chase St., City-2.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Cremation</u>	<u>May 20, 1967</u>	<u>Green Mount Crematory</u>	<u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, 1050 York Rd., 21204</u>		25. RECEIVED BY REGISTRAR <u>MAY 22 1967</u>	
		26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL ☐ ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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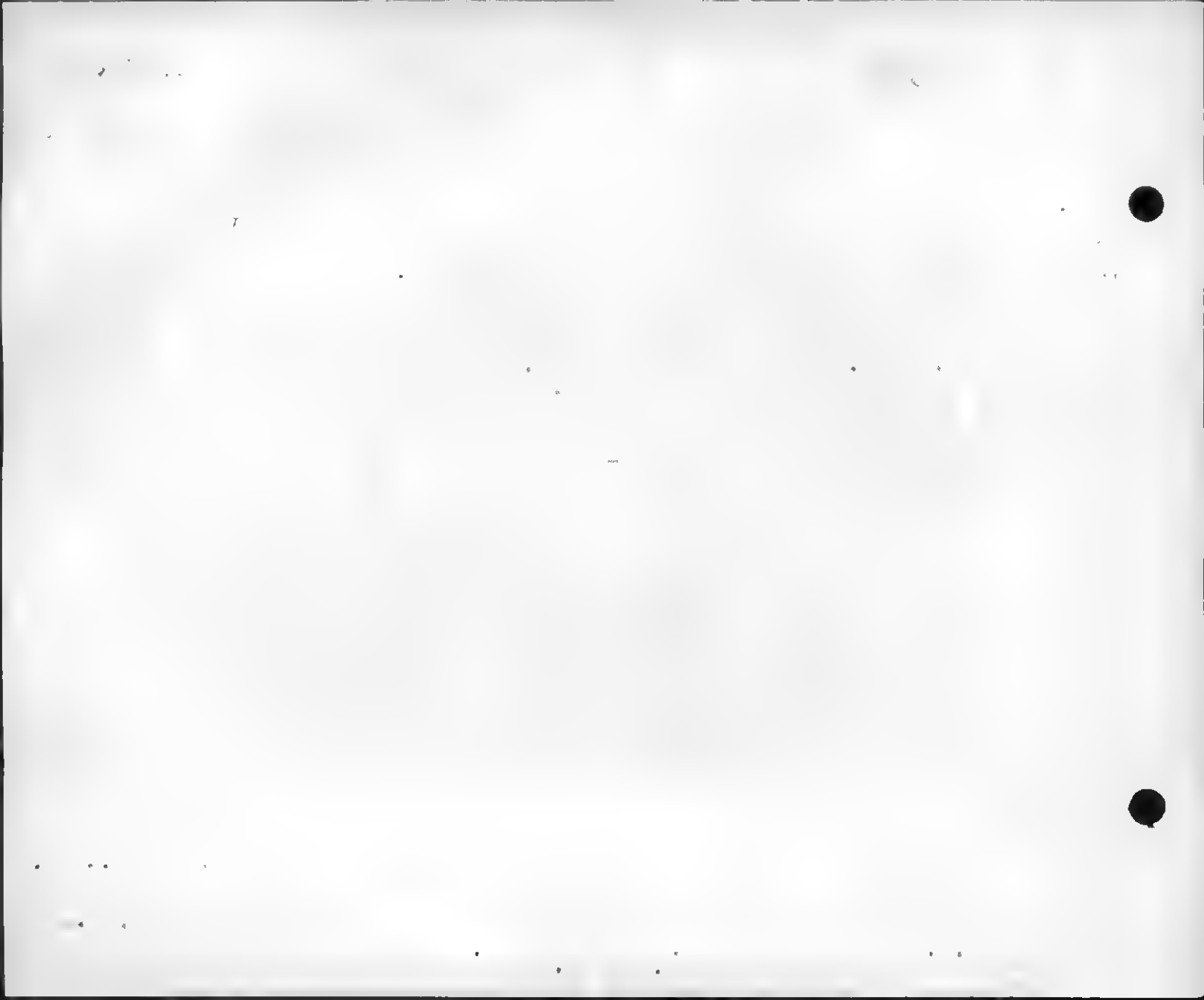
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06330

CERTIFICATE OF DEATH

06320

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c LENGTH OF STAY IN TB DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER				d STREET ADDRESS 1308 WOODBURNE AV			
3 NAME OF DECEASED (Type or print) First Middle Last EDGAR KNAUFF SR.				4 DATE OF DEATH Month Day Year 5 10 1967			
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 11, 1891	9 AGE (In years last birthday) 75 yrs.	IF UNDER 12 MONTHS Days	IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Bldg. Inspector Housing Auth.			10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) BALTIMORE BALT. Md.		
13 FATHER'S NAME William G. Knauff			14 MOTHER'S M.A.DEN NAME Nannie McIlvain				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 215-05-2625		17. INFORMANT Address HUGH KNAUFF 1357 NORTHERN PKWY			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 64 , to May 10 , 19 67 , that (I) (we) last saw the deceased alive on 4/26 , 19 67 , and that death occurred at 11 AM , from causes and on the date stated above							
22a SIGNATURE C Richard Fravel M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 5/10/67			
22c PHYSICIAN'S NAME (Type) C Richard Fravel		22d ADDRESS Medical Arts Bldg., Balto., Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/13/1967	23c NAME OF CEMETERY OR CREMATORY Parkwood		23d LOCATION (City or Town) (County) (State) Parkville, Balto. Co., Md.			
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.		25a REC'D BY REGISTRAR MAY 12 1967		25b. REGISTRAR'S SIGNATURE Richard Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06331

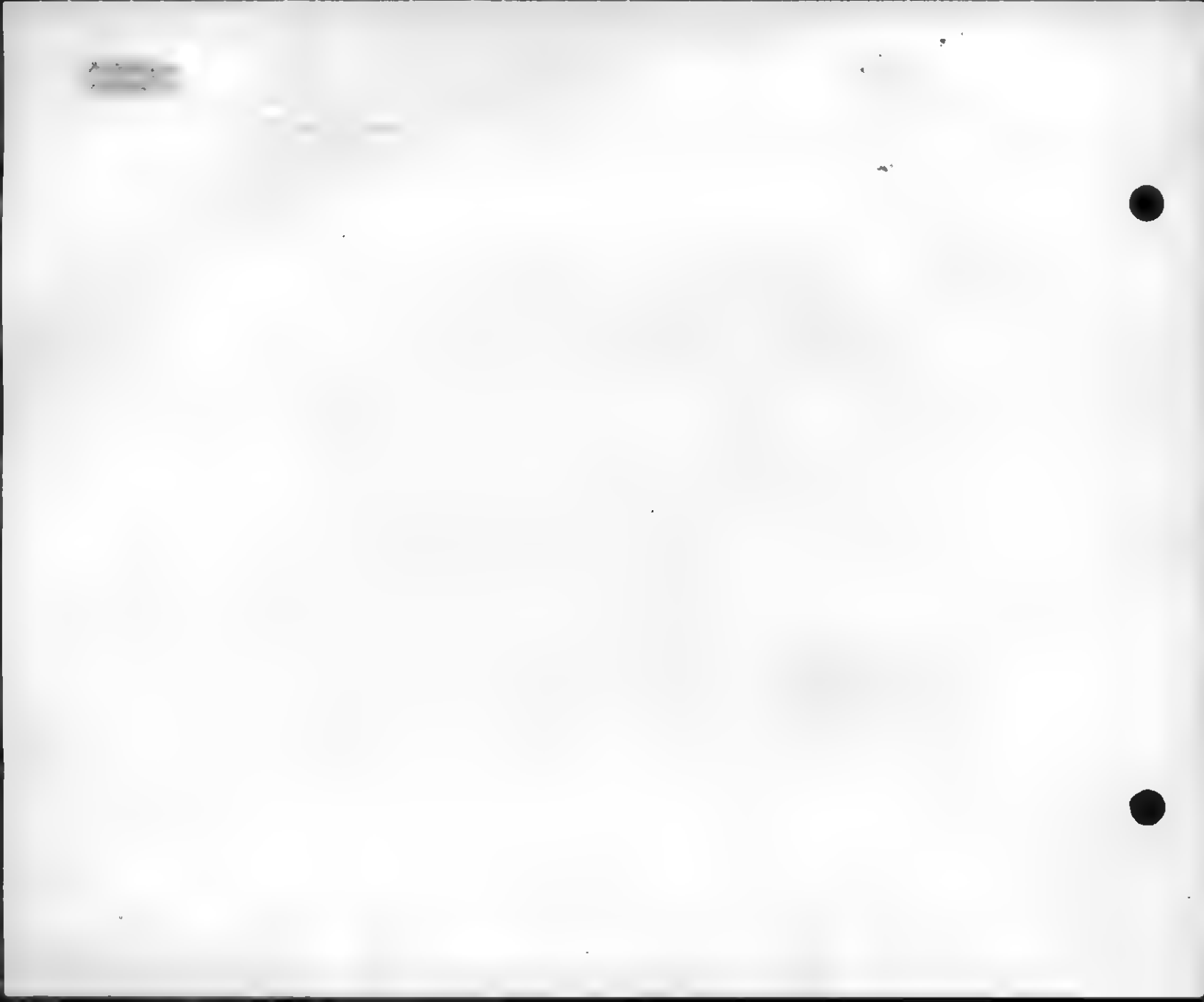
CERTIFICATE OF DEATH

06331

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1. PLACE OF DEATH a. COUNTY <u>Greater Baltimore Medical Center</u> <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>		e. STREET ADDRESS <u>6701 NORTH CHARLES STREET</u> <u>1513 Oakridge Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER PHILLIP KRAETER</u>		4. DATE OF DEATH Month Day Year <u>MAY 1st 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12.28.01</u>
9. AGE (In years last birthday) <u>65 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PHILLIP KRAETER</u>		14. MOTHER'S MAIDEN NAME <u>KOHLOPPE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-30-1568</u>	
17. INFORMANT <u>PPS HISTORY</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO _____ (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4.27.1967</u> to <u>5.1.1967</u> , that (I) <u>(we)</u> lost <u>saw</u> the deceased alive on <u>5.1.1967</u> , and that death occurred at <u>12:45 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>M. Usha Kumari</u> M.D.		22b. DATE SIGNED <u>5.1.67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. L. SERRA M. USHA KUMARI</u>		22d. ADDRESS <u>6701 NORTH CHARLES STREET - BALTIMORE, MARYLAND</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>		25a. REC'D BY REGISTRAR <u>MAY 2 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

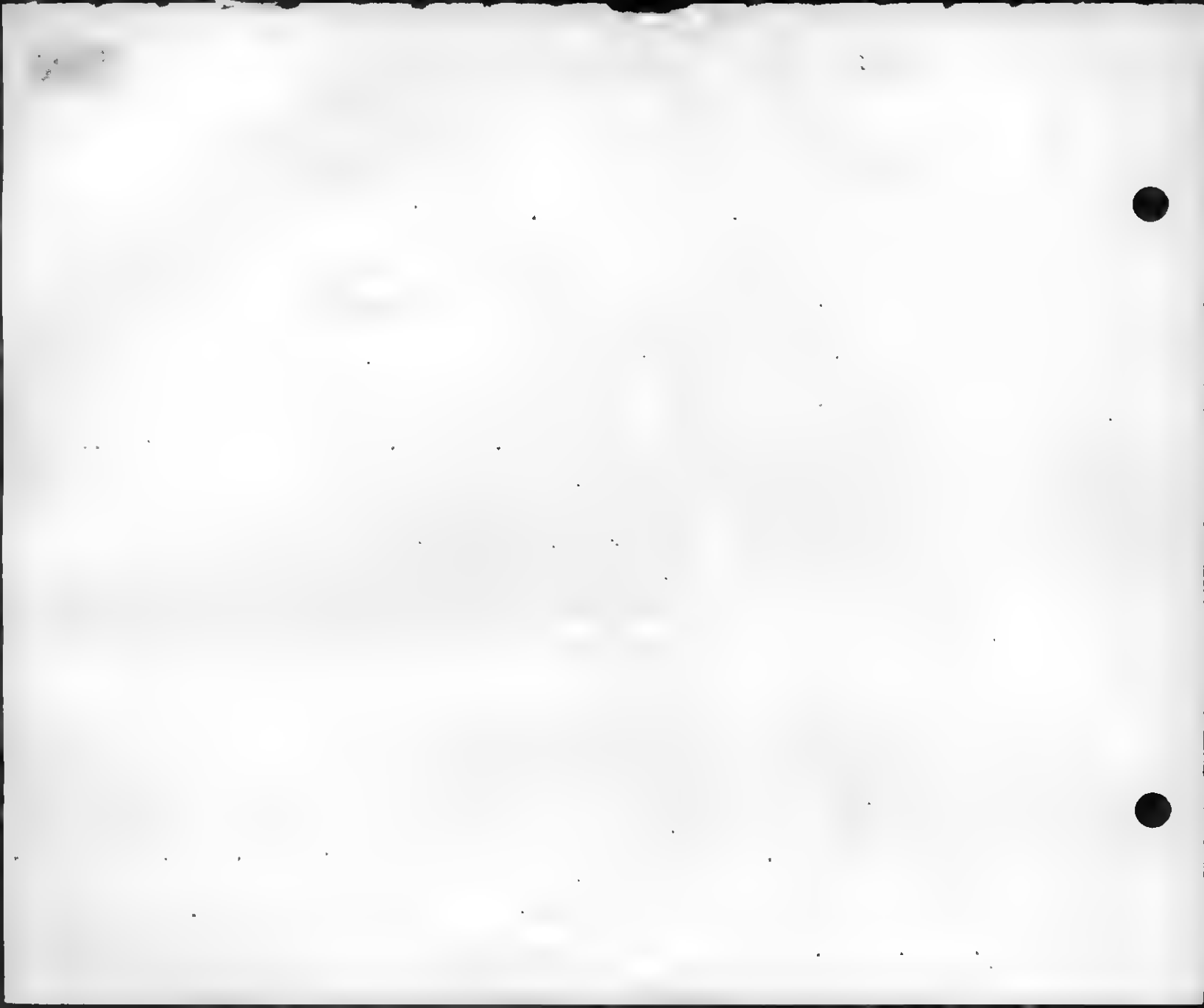


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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06332 Item #8 Film #9128 5/15/67 06332									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Baltimore					a. STATE Maryland b. COUNTY Howard				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City				
c. LENGTH OF STAY IN 1b MAYLAND					d. STREET ADDRESS 93 Bali Road				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Summit Nursing Home, 93 Smithwood Ave.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Dora		Middle		Last Krantz		4. DATE OF DEATH May 8 1967	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1984 May 20, 1886		9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Work in Bakery		10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Late Frederick Schmelz					14. MOTHER'S MAIDEN NAME Margaret				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-10-0490A		17. INFORMANT Mr. Frank M. Krantz, 107 McAlpine Rd., Ellicott City		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS, ACUTE DUE TO (b) MYOCARDIAL INFARCTION, RECENT DUE TO (c) ARTERIOSCLEROSIS CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 10/23, 1962 to 5/8, 1967, that (I) (we) last saw the deceased alive on 5/5, 1967, and that death occurred at 7 AM, from the causes and on the date stated above. 22a. SIGNATURE Paul R. Ziegler 22b. DATE SIGNED 5/8/67 22c. PHYSICIAN'S NAME (Type) Paul R. Ziegler 22d. ADDRESS 200 Chestnut Hill Dr., Ellicott City, Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF May 11, 1967 23c. NAME OF CEMETERY OR CREMATORY London Park 23d. LOCATION (City, town or county) (State) Baltimore, Md. 24. FUNERAL DIRECTOR Harry H. Witzke, 321 Columbia Pike, Ellicott City, Maryland 25a. REC'D BY REGISTRAR DATE MAY 9 1967 25b. REGISTRAR'S SIGNATURE Charles Judge									



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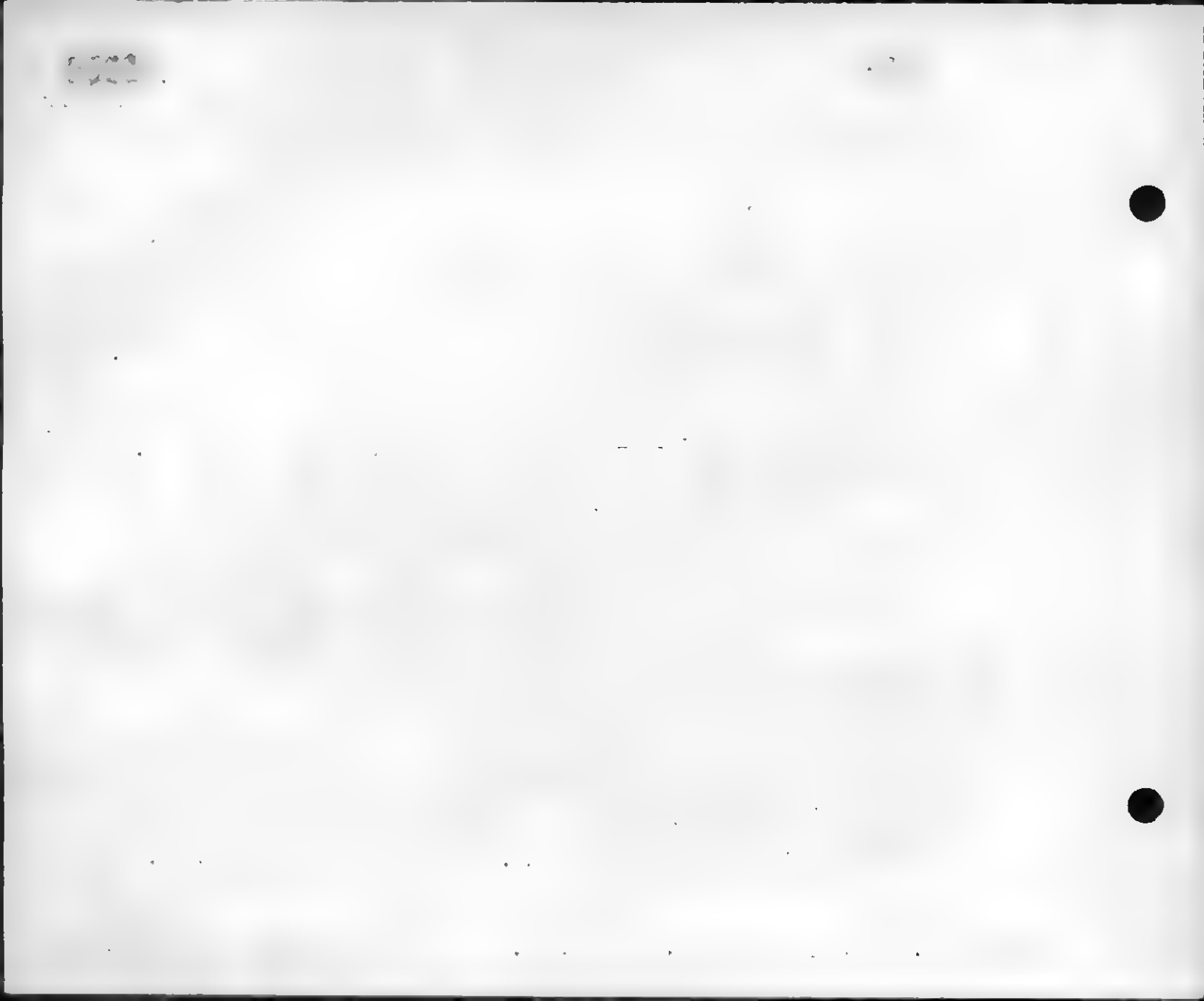
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

26333

26323

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b 4 Months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1835 Portship Road				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 1835 Portship Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mabel Middle May Last Krantz				4. DATE OF DEATH Month May Day 2 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/24/98	
9. AGE (in years last birthday) 68 yrs.		10. UNDER 1 YEAR Months Days Hours Min. 		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Louis Lanham				14. MOTHER'S MAIDEN NAME Ida Belle Wright			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-30-4334		17. INFORMANT (Son) Melvin Krantz, 7124 Crestshire Rd. Dundalk, Maryland 21222			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Abdominal cavity 1750 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severely metastatic, probably originated from ovaries (c) 						INTERVAL BETWEEN ONSET AND DEATH 5 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 15, 1965 , to May 2, 1967 , that (I) (we) last saw the deceased alive on April 28, 1967 , and that death occurred at 4:15 PM , from the causes and on the date stated above.							
22a. SIGNATURE Ataollah Golpira				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/2/67	
22c. PHYSICIAN'S NAME (Type) Ataollah Golpira				22d. ADDRESS M.D. 1942 Cedar Lane, Dundalk, Md. 21222			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/5/67		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md. 21222				25a. REC'D BY REGISTRAR MAY 4 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD
1

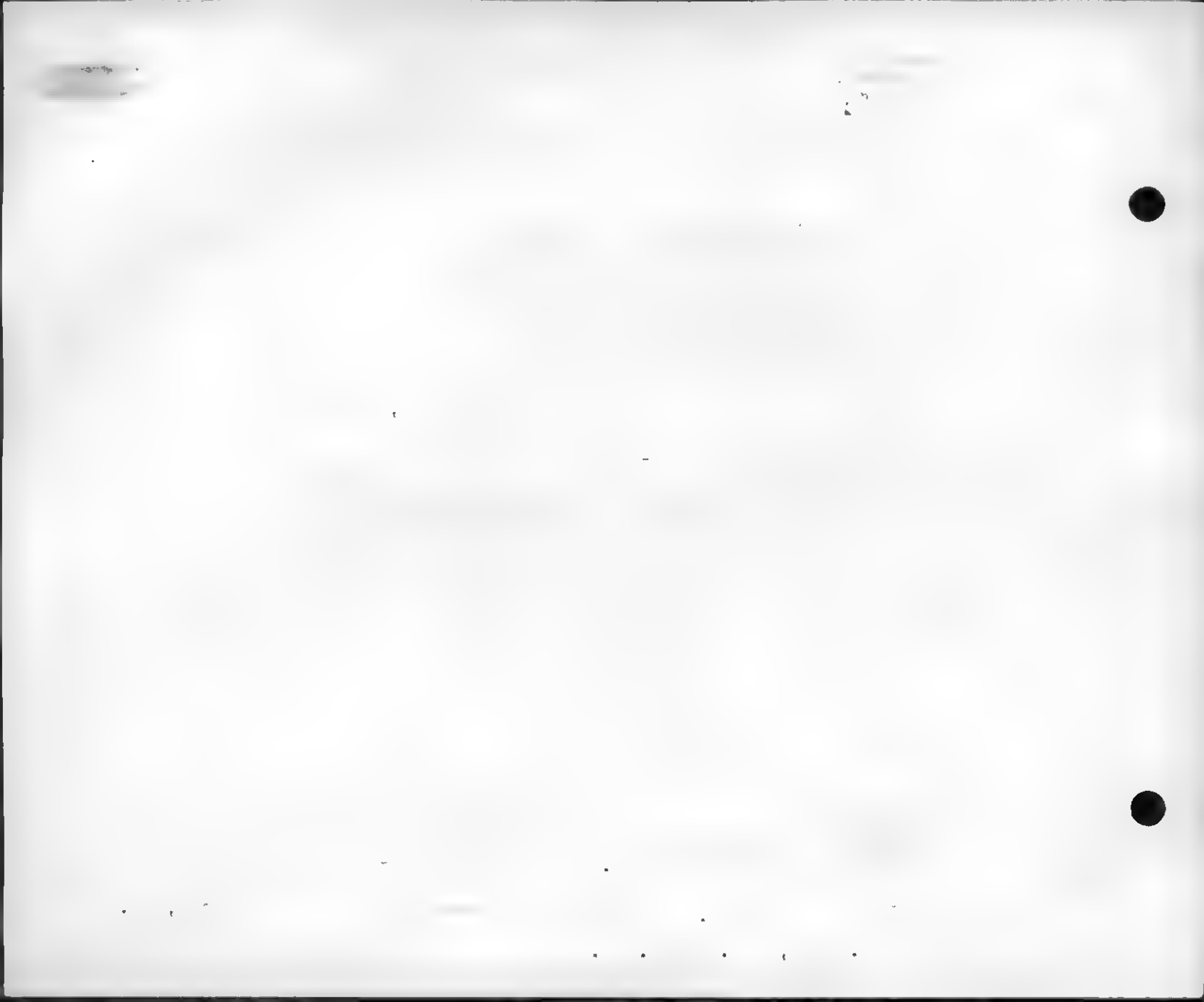
06334

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06334

1. PLACE OF DEATH a. COUNTY Towson MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN b. 17 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER				d. STREET ADDRESS 1655 Argonne Drive			
3. NAME OF DECEASED (Type or print) First Harrietta Middle N.M.N. Last Kress				4. DATE OF DEATH Month May Day 24 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/1884	9. AGE (in years last birthday) 83 yrs	10. F UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Simmons				14. MOTHER'S MAIDEN NAME Price, Harrietta			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO 217-30-4984		17. INFORMANT Mr. Richard Simmons Address Same as patient		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/8/ , 19 67 , to 5/24 , 19 67 , that (I) (we) last saw the deceased alive on 5/24 , 19 67 , and that death occurred at 2:55pm , from causes and on the date stated above.							
22a. SIGNATURE John E. Adams				22b. DATE SIGNED 5/24/67		22c. PHYSICIAN'S NAME (Type) John E. Adams, M. D.	
22d. ADDRESS Greater Baltimore Medical Center				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/27/67.		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balt. Md. 21214				25a. REC'D BY REGISTRAR MAY 29 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06335

06335

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c LENGTH OF STAY IN 1b _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d STREET ADDRESS 8219 Belair Road		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) JAMES A. KROLL First Middle Last				4 DATE OF DEATH May 30, 1967 Month Day Year			
5. SEX. Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 1, 1894		9 AGE (in years last birthday) 73 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO 212-14-8489		17. INFORMANT Dagmar Ritzman,		Address Same as # 2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) arterio-sclerotic heart dis. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH Instant 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept , 1960, to 5-30 , 1967 that (I) (we) last saw the deceased alive on 5-4 , 1967, and that death occurred at 3:15 AM , from causes and on the date stated above.							
22a SIGNATURE <i>[Signature]</i>				22b DATE SIGNED 6-1-67		22c PHYSICIAN'S NAME (Type) WM. WONG	
22d. ADDRESS 6801 BELAIR RD							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 3, 1967		23c NAME OF CEMETERY OR CREMATORY Wiesburg Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204				25a REC'D BY REGISTRAR DATE JUN 5 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

57.1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT

06336

06326

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown c. LENGTH OF STAY IN b 4 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9716 Tulsemere Road		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before death, or) a. STATE Maryland b. COUNTY BALTIMORE c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Randallstown d. STREET ADDRESS 9716 Tulsemere Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle LEE Last KRUSENKLAUS		4. DATE OF DEATH Month May Day 19 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/25/31 9. AGE (In years last birthday) 35 yrs 10. UNDER 1 YEAR Months 1 Days 19 Hours 67 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Gen Elec Supply	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Krusenklous		14. MOTHER'S MAIDEN NAME Helen Carr	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes WWII		16. SOCIAL SECURITY NO 400-38-1755	
17. INFORMANT Betty Jo Krusenklous		17b. ADDRESS 9716 Tulsemere Rd. Randallstown, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO (b) 716x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) Shot welf in head DUE TO (b) about 6:00 pm 5-19 1967 DUE TO (c) While at work Not While at work			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot welf in head	
20c. TIME OF INJURY Month, Day, Year about 6:00 pm 5-19 1967		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) home	
20e. (City or town) Baltimore (County) Md.		20f. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED May 20, 1967		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. ADDRESS (Street, city, town or county)		23b. ADDRESS (Street, city, town or county)	
23c. BURIAL, CREMATION, or other disposal (Specify) Burial		23d. DATE THEREOF 5/23/67	
23e. NAME OF CEMETERY OR CREMATORY Calvary		23f. LOCATION (City or town) (County) (State) Louisville Jefferson Ky.	
24. FUNERAL DIRECTOR Long Byers		24a. ADDRESS 8728 Liberty Rd Randallstown Md	
24b. DATE MAY 22 1967		24c. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove ~~these~~ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

(M)

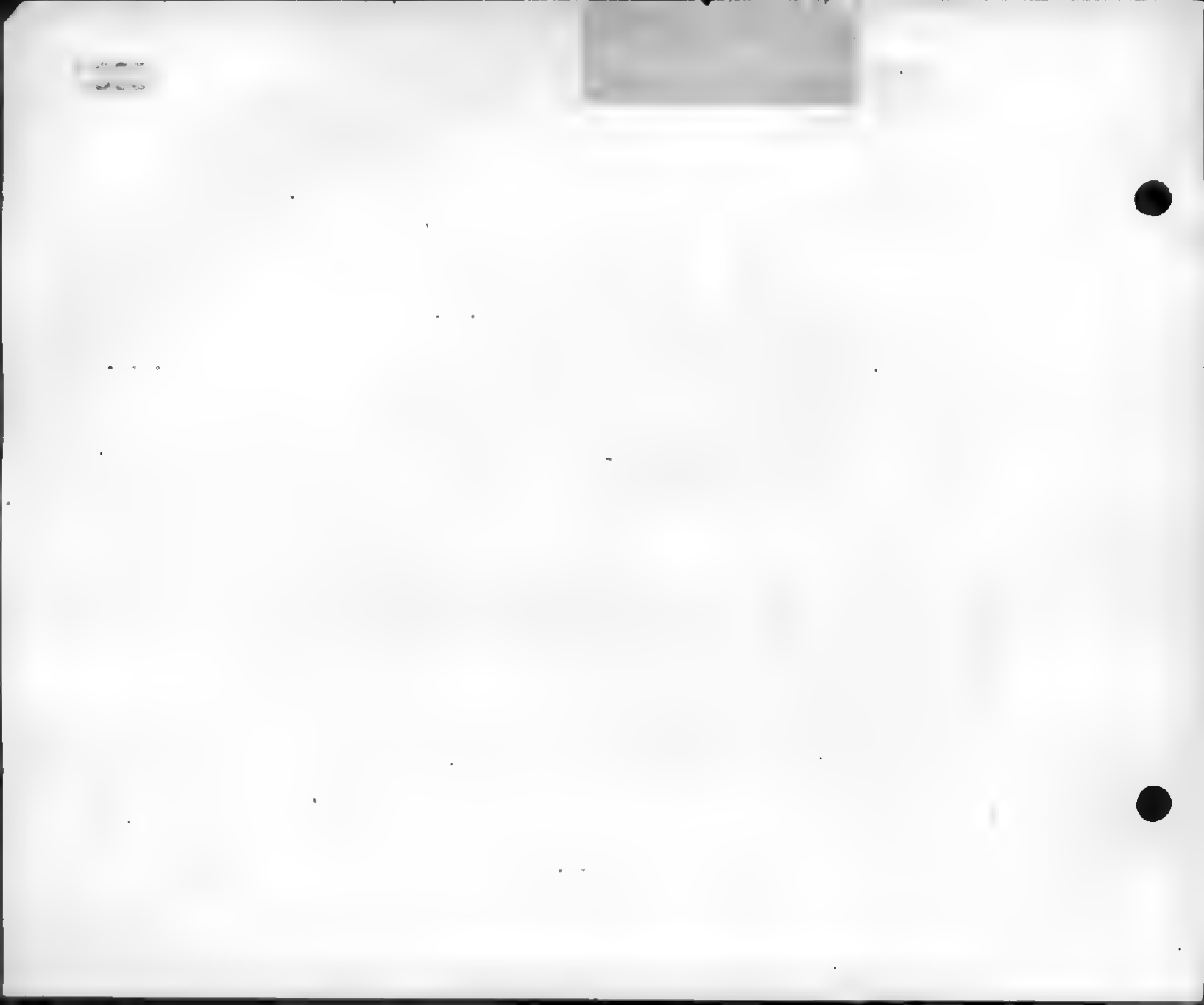
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06337

06327

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 27yr3mth7dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. STREET ADDRESS 1227 Glyndon Street	
3. NAME OF DECEASED (Type or print) First Mary Middle Kuszlis Last Kuszlis		4. DATE OF DEATH Month May Day 16 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1891
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker		10b. KIND OF BUSINESS OR INDUSTRY Sailor Shop	
11. BIRTHPLACE (County & State, or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Maichael Kaiser		14. MOTHER'S MAIDEN NAME Antoinette Sherpenskas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 215-05-8037	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary emboli DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 to 8 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that it (this hospital) attended the deceased from Feb. 9, 1939 to May 16, 19 67 , that it (we) last saw the deceased alive on May 16, 19 67 , and that death occurred at 3:55 M, from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young</i>		22b. DATE SIGNED 5-17-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/20/67	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	23d. LOCATION (City or Town) (County) (State) 4436 Belair Rd. Md.
24. FUNERAL DIRECTOR <i>John J. Lawrence</i>		25a. REC'D BY REGISTRAR MAY 18 1967	
ADDRESS 401 Belair St.		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	



HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

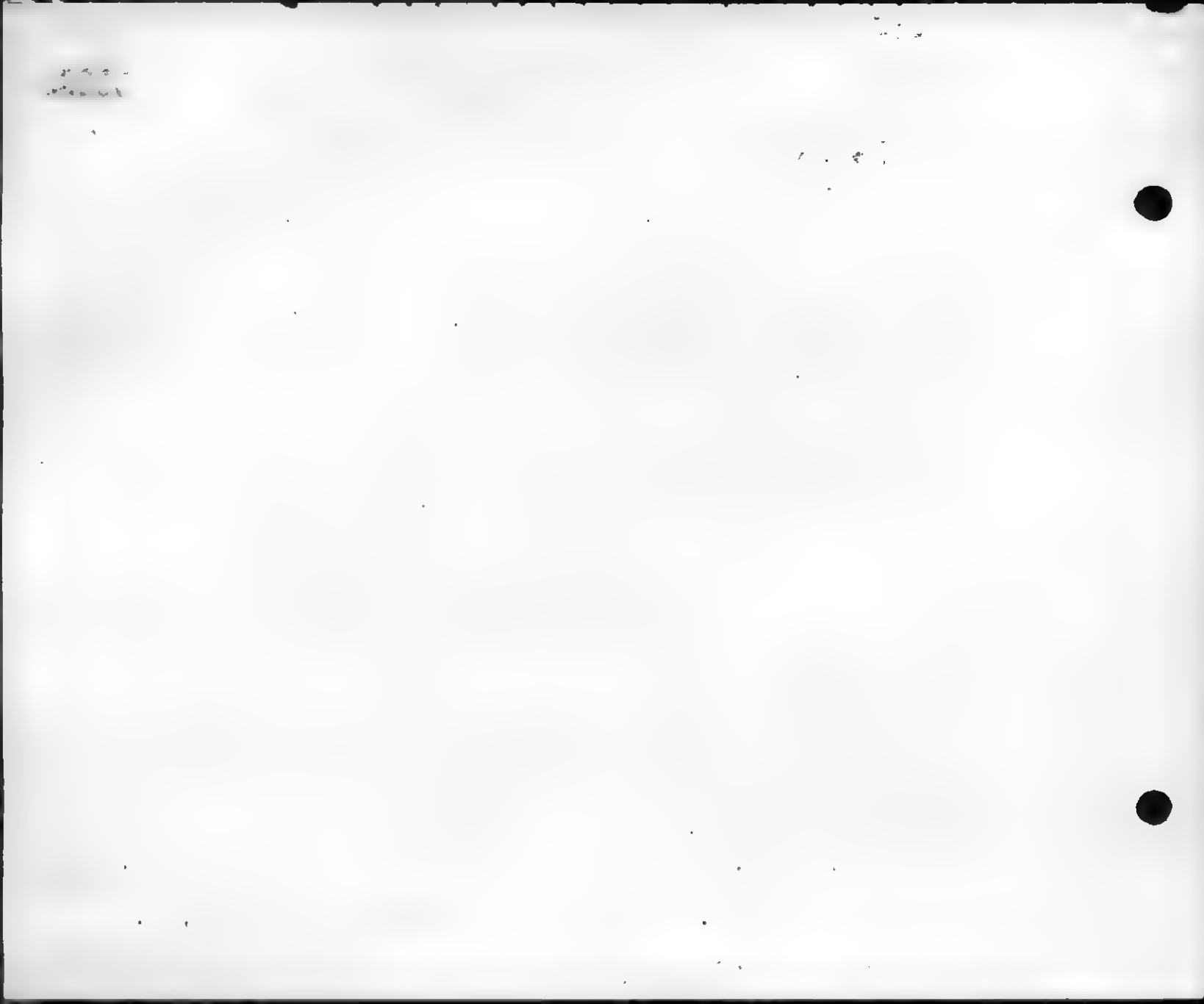
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06338

06328

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE Ma ryland b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Baltimore City		c LENGTH OF STAY IN Id RURAL Baltimore City	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 221 Bowleys Quarters Road		d. STREET ADDRESS 221 Bowleys Quarters Road	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) A N T H O N Y First L A G N A Middle L A G N A Last		4 DATE OF DEATH Month May Day 8 Year 19 67	
5 SEX male	6. COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 17, 1888
9 AGE (In years last birthday) 79 yrs		10 UNDER 1 YEAR Months 12 Days 19 Hours 67 Min	11 UNDER 24 HRS Hours 67 Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cement finisher, retired		10b KIND OF BUSINESS OR INDUSTRY Italy	
11 BIRTHPLACE (County & State, or foreign country)		12 CIT ZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME ? Lagna		14. MOTHER'S MA DEN NAME Dominica ?	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO 214-01-2010	
17. INFORMANT Mrs. Pose Martin--221 Bowleys Quarters Rd.--20		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon DUE TO (b) Metastasis To Liver DUE TO (c) " Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Jan 1967 " 1967	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21 I certify that (I) (the hospital) attended the deceased from Sept , 19 64 , to May 8 , 19 67 , that (I) (we) last saw the deceased alive on May 8 , 19 67 , and that death occurred at 8:30 M. from causes and on the date stated above.			
22a. SIGNATURE John W. Ashworth		22b. DATE SIGNED 5/9/67	
22c. PHYSICIAN'S NAME (Type) Dr. John W. Ashworth		22d. ADDRESS 1129 St. Paul St., Balto., Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) burial	23b DATE THEREOF 5/12/67.	23c NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc.--Baltimore, Md.--14		25a. REC'D BY REGISTRAR DATE MAY 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06333

CERTIFICATE OF DEATH

06329

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing Home		d. STREET ADDRESS 2409 Annapolis Rd. 21230	
3. NAME OF DECEASED (Type or print) First Mynard Middle E. Last Lake		4. DATE OF DEATH Month May Day 28 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/17/85
9. AGE (In years last birthday) 82 yrs		10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Financial Secretary		10b. KIND OF BUSINESS OR INDUSTRY IUOE	
11. BIRTHPLACE (County & State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edwin Lake		14. MOTHER'S MAIDEN NAME Catherine Maney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-10-6176	
17. INFORMANT Mrs. Dorothy M. Orem		Address 21230 2409 Annapolis Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 months +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 28, 1967 to May 25, 1967 , that (I) (we) last saw the deceased alive on May 25, 1967 , and that death occurred at 10 P.M. from causes and on the date stated above.			
22a. SIGNATURE John A. Nesbitt JR.		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED 5-31-67
22c. PHYSICIAN'S NAME (Type) John A. Nesbitt JR.		22d. ADDRESS 1009 Frederick Road	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/1/67	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	25a. REC'D BY REGISTRAR JUN 2 1967
		25b. REGISTRAR'S SIGNATURE John A. Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

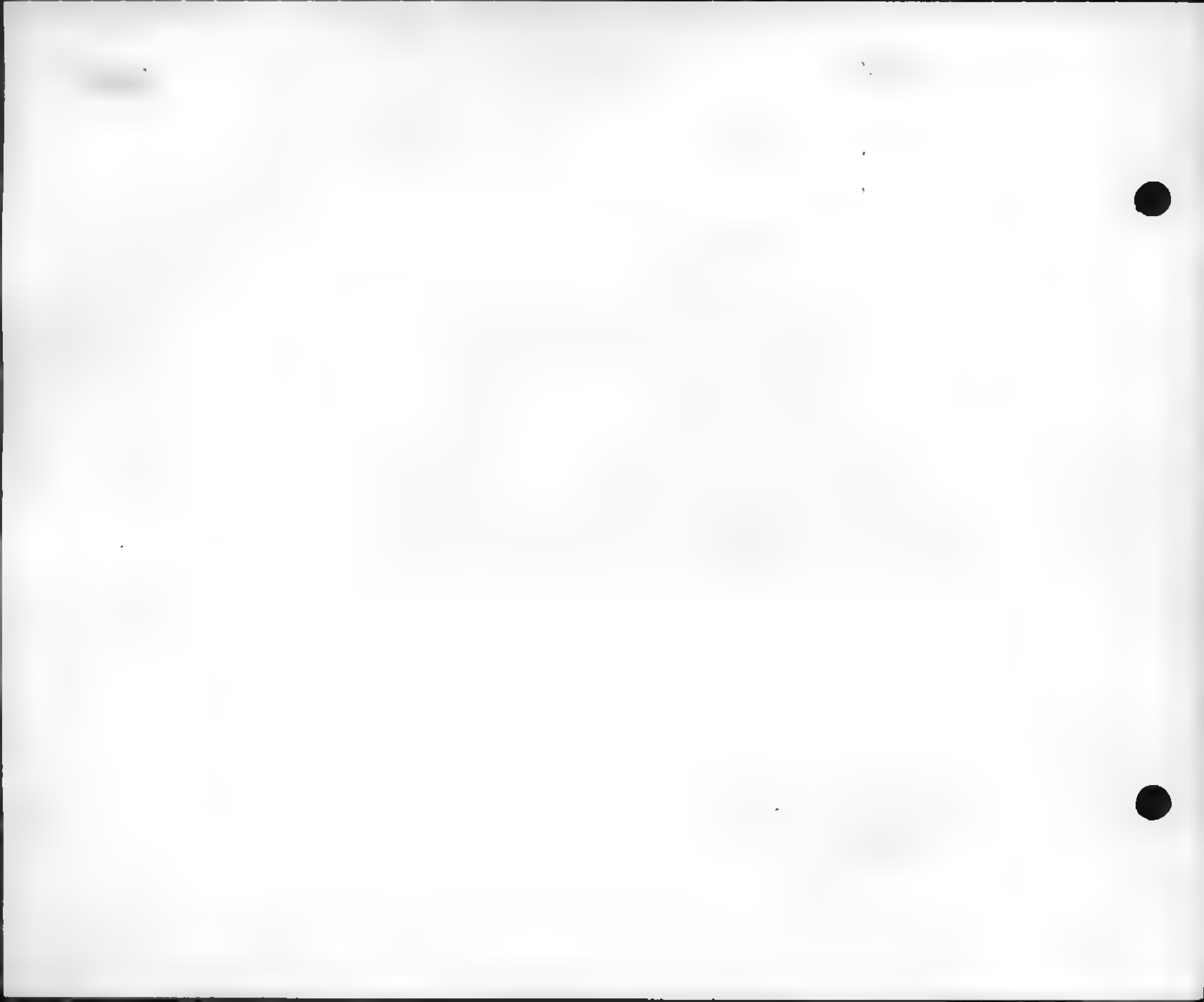
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06340

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05330

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Dundalk	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Dundalk		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) 7245 Holabird		d STREET ADDRESS 7245 Holabird Ave	
3 NAME OF DECEASED (Type or print) William R Lane First Middle Last		4 DATE OF DEATH May 6 / 67 Month Day Year	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> WIDOW <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 16 1914
9 AGE (In years, lay, Sunday) 52 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Steel		11b KIND OF BUSINESS OR INDUSTRY Beth Steel	
12 BIRTHPLACE (State or foreign country) Penna		13 CITIZEN OF WHAT COUNTRY?	
14 FATHER'S NAME William Lane		15 MOTHER'S MAIDEN NAME Nell O Toole	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17 SOCIAL SECURITY NO	
18 INFORMANT Terry P Lane Address 7245 Holabird Ave			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO (b) Hypertension C-V-Disease Conditions if any which gave rise to immediate cause (a), stating the underlying cause last (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc)	20f City, town, County, State
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M B Davis M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Melvin B Davis 6800 Morningside Road		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL CREMATION REMOVAL (Specify) removal		23b DATE THEREOF May 6/67	
23c NAME OF CEMETERY OR CREMATORY St Johns Cem		23d ADDRESS Scottsdale Pa	
24 FUNERAL DIRECTOR Ullrich Funeral Home 2112 Dundalk Ave Dundalk		25a REC'D BY Scottsdale Judge DATE MAY 11 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event within 72 hours after death.

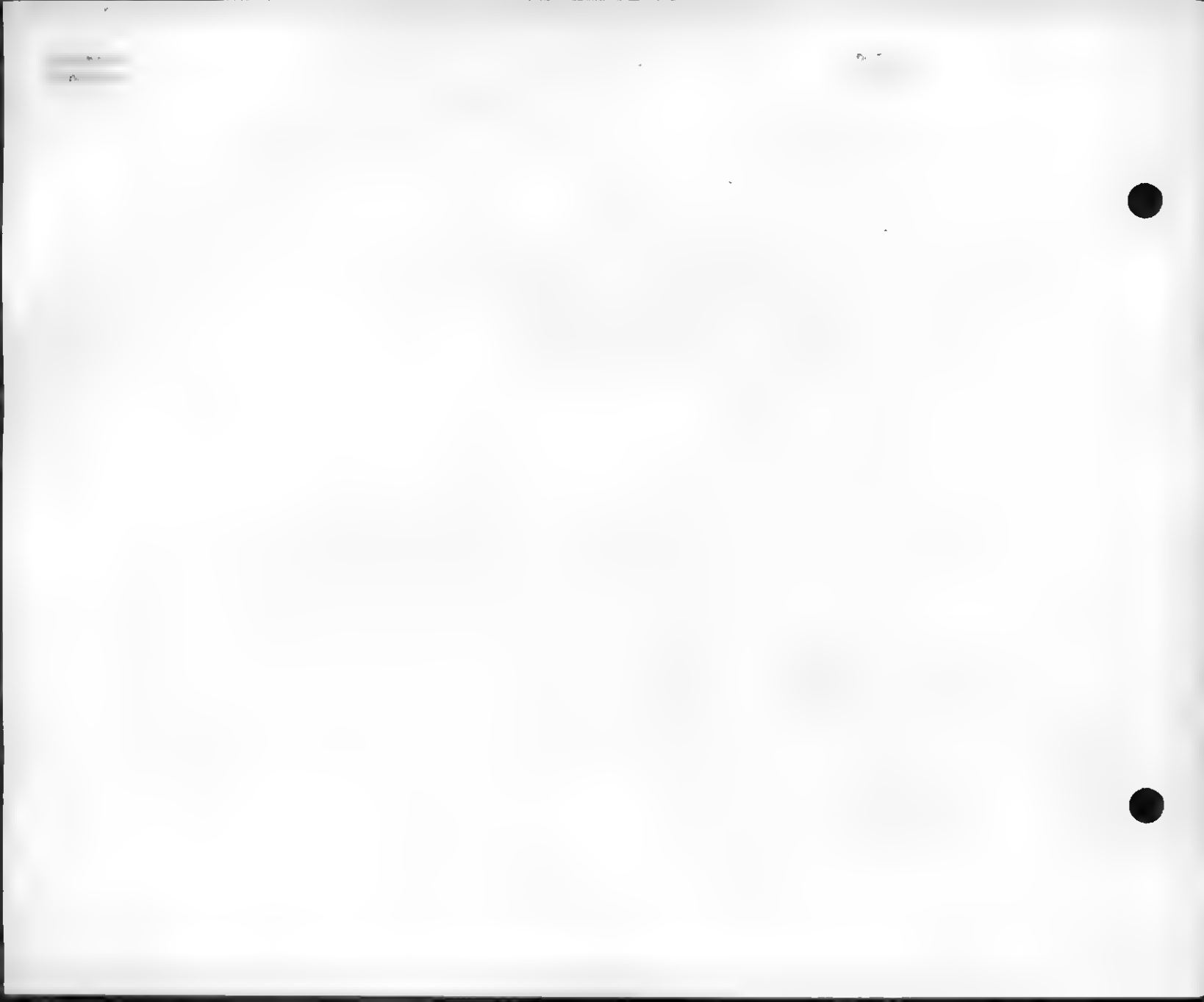
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06341

CERTIFICATE OF DEATH

06331

1 PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11 NEWBURG AVE</u>		d. STREET ADDRESS <u>11 NEWBURG AVE</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>CATHERINE O. LANG</u>		4 DATE OF DEATH Month Day Year <u>MAY 17 19 67</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/29/81</u>
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>85</u> yrs
11 BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>JOHN INGALLS</u>		14 MOTHER'S MAIDEN NAME <u>ALVERDIA JOHNSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>MRS. T. ALLAN MUIR</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4500</u> <u>Uremia Dehydration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic arteriosclerosis - severe</u> DUE TO (c) <u>Chronic cardiac failure</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>17 May</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>17 May</u> , 19 <u>67</u> , and that death occurred at <u>17</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>William J. Bryson</u>		22b. DATE SIGNED <u>18 May 67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>BURIAL</u>	<u>5/19/67</u>	<u>WESTERN</u>	<u>BALTO, MD.</u>
24. FUNERAL DIRECTOR <u>E.S. MALNABIZ</u>		25a. REC'D BY REGISTRAR <u>301 FREDERICK RD</u>	
25b. REGISTRAR'S SIGNATURE <u>212 28</u>		25c. REC'D BY REGISTRAR <u>MAY 29 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06342

JD332

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.)

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c LENGTH OF STAY IN 15 <u>2 days</u>			
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lepros Mill Road</u>				d STREET ADDRESS <u>Lepros Mill Road</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brester Baltimore Medical Center</u>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Elizabeth Lathe</u>				4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1967</u>			
5 SEX <u>F</u>	6 COLOR OR RACE <u>Cau</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5/21/1889</u>	9 AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NA</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13 FATHER'S NAME <u>Charles Lathe</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>113-03-9181</u>		17. INFORMANT Address <u>Patient Chart</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Vascular Disease</u> DUE TO <u>Congestive Heart Failure</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST <u>Acute myocardial infarction</u> DUE TO (c) <u>Acute myocardial infarction</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	
				20f (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from <u>May 10th, 1967</u> , to <u>May 12th, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 12th, 1967</u> , and that death occurred at <u>9:30 AM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>H. Saballe MacGo</u> M.D.				22b. DATE SIGNED <u>5-12-67</u>		22c. PHYSICIAN'S NAME (Type) <u>DR. ROBERT ENSOR</u>	
22d ADDRESS <u>Old Baltimore Medical Center</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>May 15 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Bernard Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Harrisonville, Md.</u>	
24 FUNERAL DIRECTOR <u>Frank H. Newell</u>				25a. REC'D BY REGISTRAR <u>Charles George</u>		25b. REGISTRAR'S SIGNATURE <u>Charles George</u>	
				DATE <u>MAY 16 1967</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06343

CERTIFICATE OF DEATH

16333

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b 20 Days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center				e. STREET ADDRESS 294 Stillwater Road			
3. NAME OF DECEASED (Type or print) First MARGARET Middle LEBRUN Last LEBRUN				4. DATE OF DEATH Month May Day 11 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/16/07	9. AGE (In years last birthday) 59 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Baltimore		12. C. T. ZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Henry Fred Komber				14. MOTHER'S MAIDEN NAME Beckhold			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT Patient's History			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Rectum DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 22, 19 67 to May 11, 19 67 , that (I) (we) last saw the deceased alive on May 11, 19 67 , and that death occurred at 2:00 p.m. , from causes and on the date stated above.							
22a. SIGNATURE John E. Adams				22b. DATE SIGNED 5/11/67		22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D.	
22d. ADDRESS Greater Baltimore Medical Center							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/15/67		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION (City or Town) (County) (State) Balto Md	
24. FUNERAL DIRECTOR John Connolly Son				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE MAY 15 1967							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillside, Maryland	
c. LENGTH OF STAY IN 1b 2yr2mth28days		d. STREET ADDRESS 1402 - 49th Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ethel Middle NMN Last Leigh		4. DATE OF DEATH Month May Day 8 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1898
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min.	11. IF UNDER 24 HRS. Months 68 Days 68 Hours 68 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles Hines		14. MOTHER'S MAIDEN NAME Anna Leahy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-05-2575B	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) Arteriosclerosis, Generalized, senile DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension; Left cerebral hemorrhage (2 yrs. ago).		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that OK (this hospital) attended the deceased from Feb. 10, 1965 to May 8, 1967 , that no (we) last saw the deceased alive on May 8, 1967 , and that death occurred at 3:00 M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young</i>		22b. DATE SIGNED 5-8-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) 5-11-67		23b. DATE THEREOF 5-11-67	
23c. NAME OF CEMETERY OR CREMATORY NASH NAT'L Park		23d. LOCATION (City, town or county) (State) Suitland Pk. Co. MD	
24. FUNERAL DIRECTOR W. H. Hines & Co.		25a. REC'D BY REGISTRAR 517 11	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE MAY 11 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit and please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

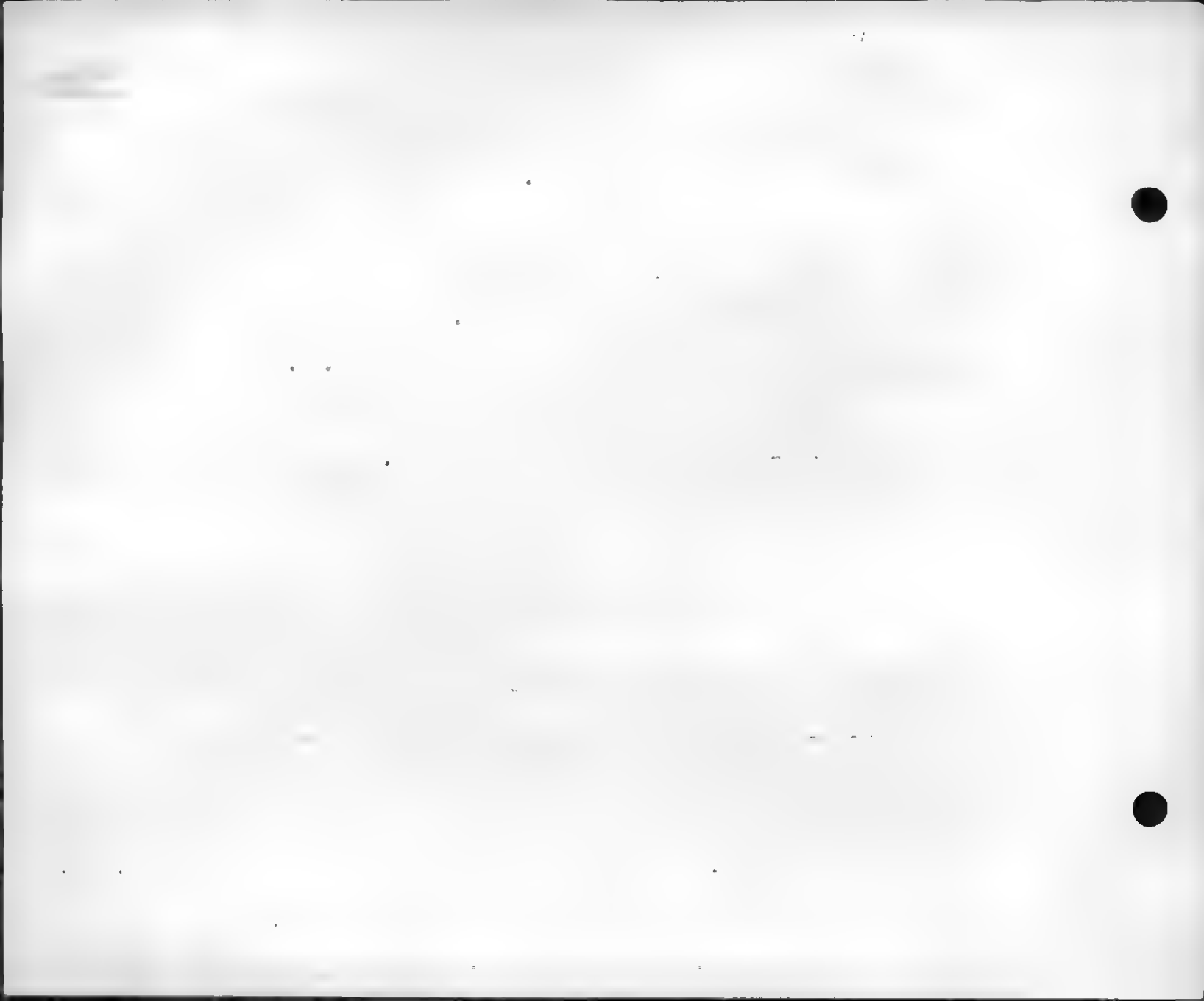
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06345

CERTIFICATE OF DEATH

06345

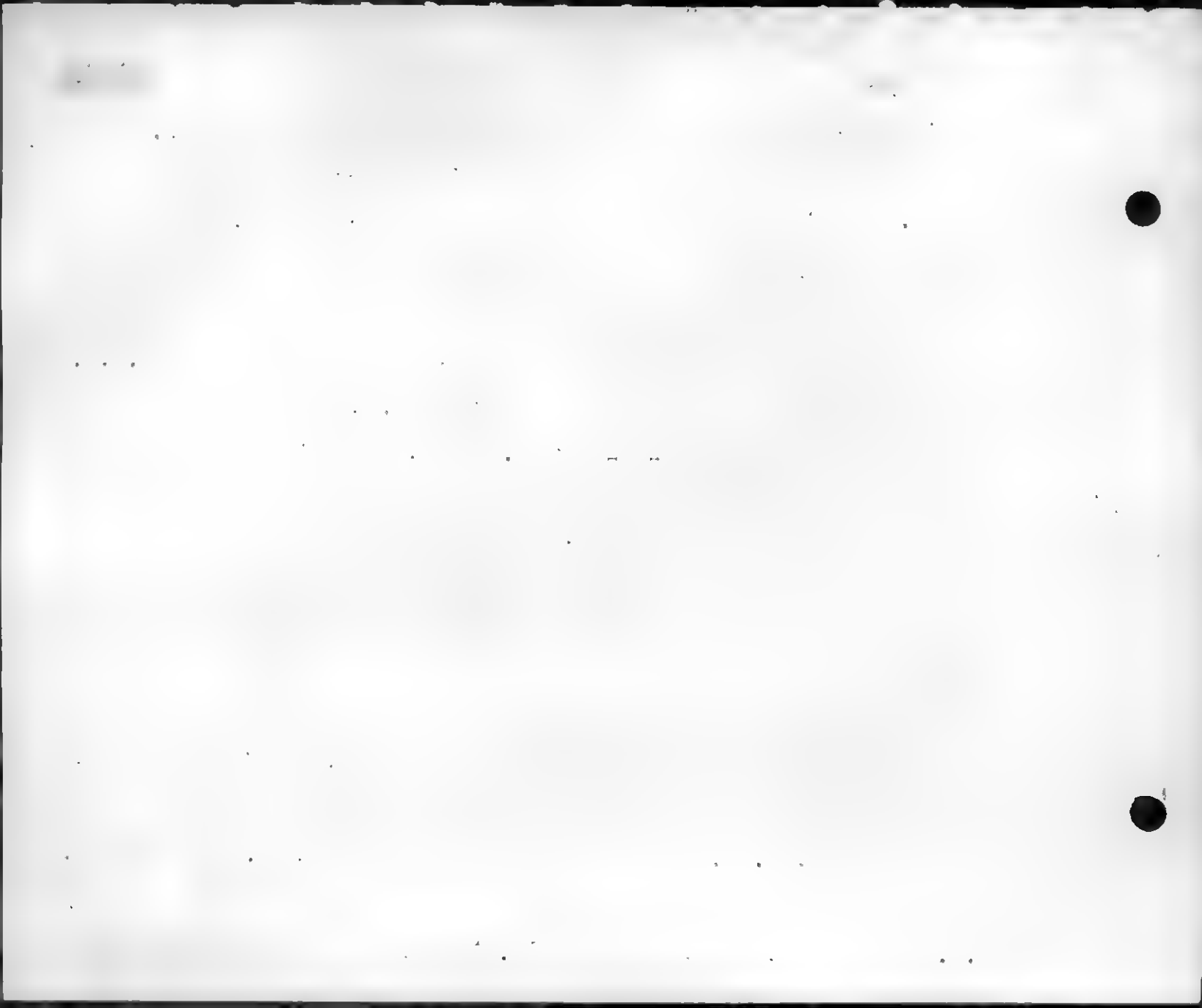
1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c LENGTH OF STAY IN 1b 16 Yrs.	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 109 Manor Avenue		d STREET ADDRESS 109 Manor Avenue	
3 NAME OF DECEASED (Type or print) Donald F. Linch		4 DATE OF DEATH Month May Day 17 Year 1967	
5 SEX Male	6 COLOR OR RACE Caucasian	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec. 23 1909
9 AGE (In years last birthday) 57 yrs		10 IF UNDER 1 YEAR Months Days	11 IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) Superintendent		10b KIND OF BUSINESS OR INDUSTRY Continental Can Co	
11 BIRTHPLACE (County & State, or foreign country) Buffalo, N. Y.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Henry Linch		14 MOTHER'S MAIDEN NAME Grace Curtin	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 070-10-4665	
17 INFORMANT Catherine M. Linch		Address 109 Manor Avenue 21206	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) Congestive heart failure DUE TO (c) Aortic stenosis and mitral insufficiency			INTERVAL BETWEEN ONSET AND DEATH at least 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. May 15 1967	20d INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> or work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) this hospital attended the deceased from 1963 , 19 May 15 19 67 , and that death occurred at 2 PM , from causes and on the date stated above.			
22a SIGNATURE Crawford N. Kirkpatrick, Jr.		22b. DATE SIGNED May 18, 1967	
22c. PHYSICIAN'S NAME (Type) Crawford N. Kirkpatrick M.D.		22d ADDRESS 6 East Eager St. Balto. Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF May 20, 1967	23c NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	23d LOCATION (City or town) (County) (State) Balto. Md.
24. FUNERAL DIRECTOR The Dippel Bro's Inc. 7110 Belair Rd.		25a. REC'D BY REGISTRAR May 10 1967	25b. REGISTRAR'S SIGNATURE Michael Judge



THE HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

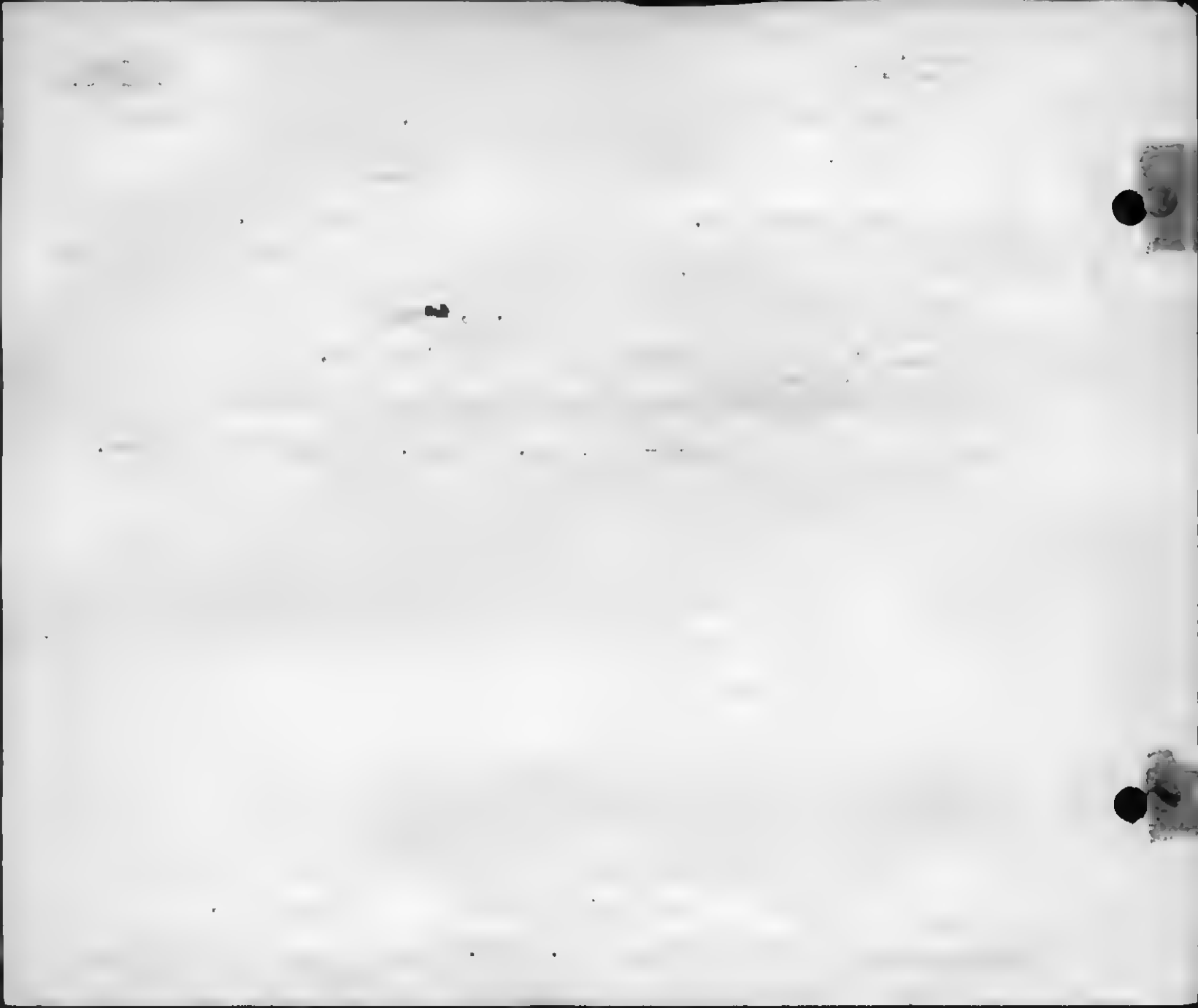
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 34 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Josephs Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 34 d. STREET ADDRESS 9322 Old Harford Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Olive Maria Longbottom		4. DATE OF DEATH Month Day Year 5 4 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1883
9. AGE (in years last birthday) 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel McClain		14. MOTHER'S MAIDEN NAME Sarah E. Gerber	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-48-2133	
17. INFORMANT B. Bruce Longbottom		Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular-renal dis DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1944 to May 4, 1967 that (I) (we) last saw the deceased alive on April 14, 1967 and that death occurred at 7:25 PM from the causes and on the date stated above.			
22a. SIGNATURE A. M. Bacon		22b. DATE SIGNED 5/5/67	
22c. PHYSICIAN'S NAME (Type) Dr. A. M. Bacon		22d. ADDRESS 2810 Taylor Ave., Balto. 34, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Parkwood	23d. LOCATION (City, town or county) (State) Parkville Md.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd., Balto. 12 Md.		25a. REC'D BY REGISTRAR 5 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon numbers 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 606 Highland Ave.					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 606 Highland Ave.				
3. NAME OF DECEASED (Type or print) Susanne Lyness					4. DATE OF DEATH Month May Day 23 Year 1967				
5. SEX Female					6. COLOR OR RACE White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH Oct. 4, 1896				
9. AGE (In years last birthday) 70 yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.				
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME James Myers					14. MOTHER'S MAIDEN NAME Mary Gertrude McGuigan				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 161-09-6998 B				
17. INFORMANT Mr. Arthur A. Lyness, 606 Highland Ave.					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Hypertensive Cardiovascular Disease					INTERVAL BETWEEN ONSET AND DEATH 5 minutes 5 years 10 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1956 to 5/23/1967 , that (I) (we) last saw the deceased alive on 5/11/1967 , and that death occurred at 3 A M, from the causes and on the date stated above.									
22a. SIGNATURE Robert T. Parker					22b. DATE SIGNED May 23, 1967				
22c. PHYSICIAN'S NAME (Type) ROBERT T. PARKER					22d. ADDRESS SOUTH BALTO. GENERAL HOSP. Balto 30				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 5/26/67				
23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery					23d. LOCATION (City, town or county) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE B. Vernon Lemmon					25a. REC'D BY REGISTRAR MAY 26 1967				
25b. REGISTRAR'S SIGNATURE Charles Judge									

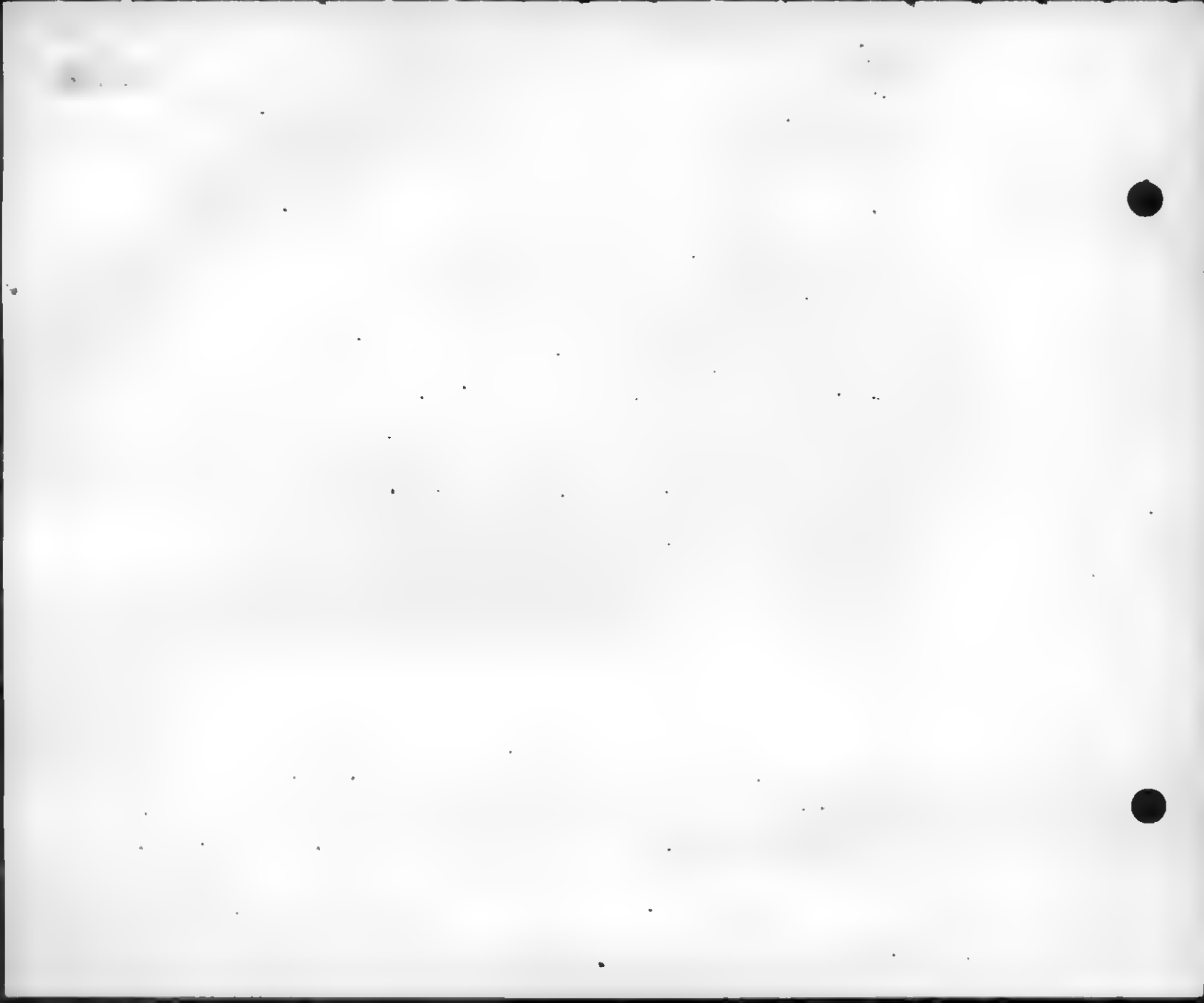
VII A15 (4)
15M 9/60



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 329 Hillen Rd. 21204	
3. NAME OF DECEASED (Type or print) First Charles Middle E. Last Mack		4. DATE OF DEATH Month May Day 27 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-22
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR: Months 4 Days 1 Hours 1 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward Mack		14. MOTHER'S MAIDEN NAME Bessie Watkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Edward Mack		Address 325 Linnoville Ave. Towson	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe Cirrhosis of the liver 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malnutrition DUE TO (c) Cardiac failure			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 26 , 19 67 , to May 27 , 19 67 , that (I) (we) last saw the deceased alive on May 27 , 19 67 , and that death occurred at 6:45 PM on the causes and on the date stated above.			
22a. SIGNATURE Benjamin Del Carmen		22b. DATE SIGNED 5-27-67	
22c. PHYSICIAN'S NAME (Type) Benjamin Del Carmen		22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 5/31/67	23c. NAME OF CEMETERY OR CREMATORY Greenmount Rest	23d. LOCATION (City, town or county) (State) Towson, Balto. Co Md.
24. FUNERAL DIRECTOR Del. Del Carmen		25a. REC'D BY REGISTRAR MAY 31 1967	
25b. REGISTRAR'S SIGNATURE Del. Del Carmen		25c. REGISTRAR'S SIGNATURE Del. Del Carmen	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

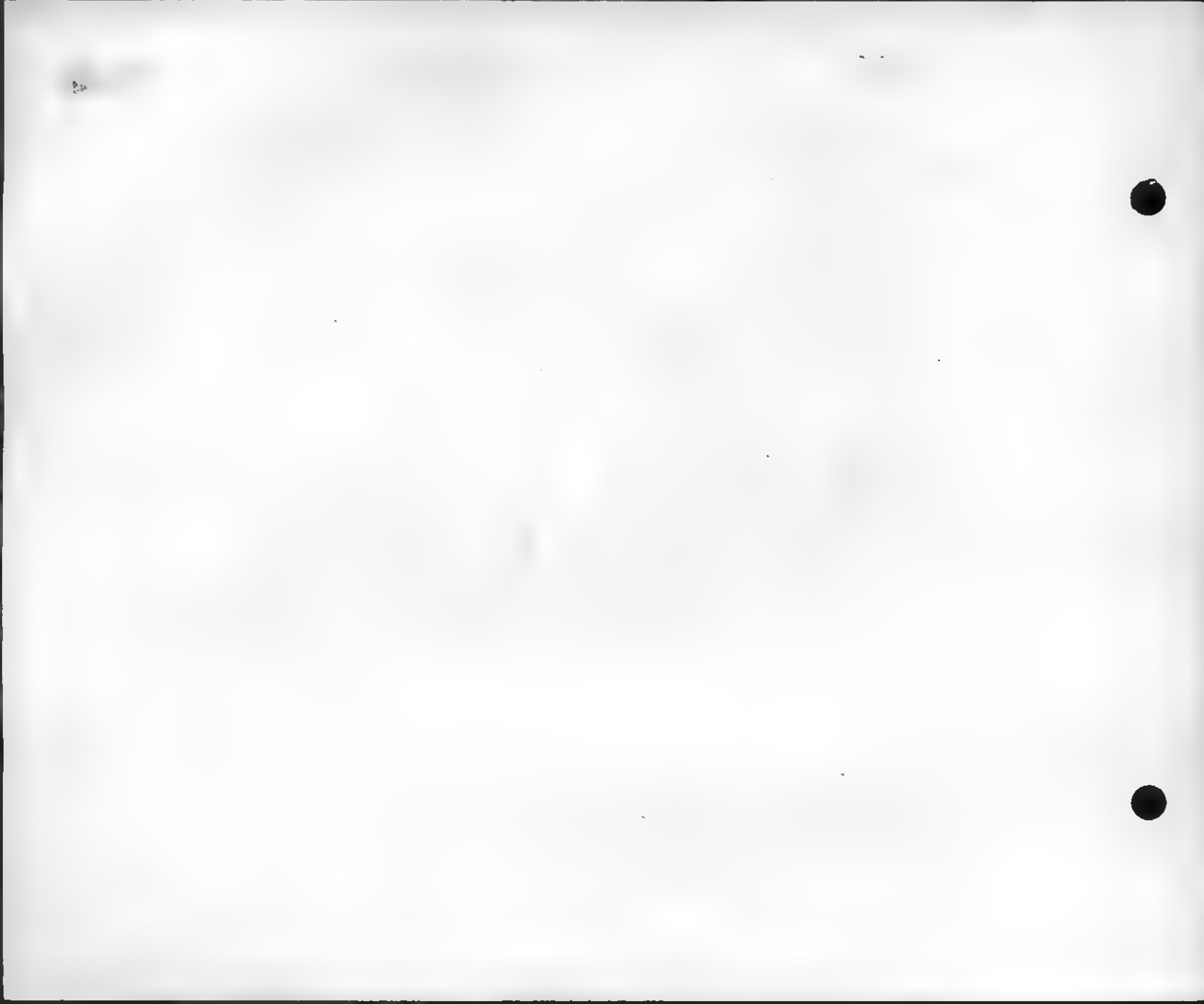
FOR STATE HEALTH DEPT.

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Item 9 Film G-109 5/25/67 KK
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06349

06349

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived or institution where residence before admission) a. STATE Baltimore Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON Baltimore				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) Saint Joseph Hospital				d. STREET ADDRESS Dartmouth Ave 134			
3 NAME OF DECEASED (Type or print) First Joseph Middle I Last Mackin				4 DATE OF DEATH Month May Day 21 Year 1967			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 1907 July 31	
9 AGE (In years last birthday) 59		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Retired		10b. KIND OF BUSINESS OR INDUSTRY Auto Supply		11 BIRTHPLACE (State or foreign country) BALTO Md	
12 CITIZEN OF WHAT COUNTRY? USA				13 FATHER'S NAME James Mackin			
14 MOTHER'S MAIDEN NAME Mary McKay				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes WW II			
16 SOCIAL SECURITY NO. 217-07-1219				17 INFORMANT Fam. Lg. Records			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion Sudden (b) Myocardial Infarction (c) Anterior wall Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 5+ years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Diabetes							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell				22. DATE SIGNED 5/21/67			
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.				Address (Street, city, town or county)			
23a. MANNER OF CREMATION BURIAL		23b. DATE THEREOF 5-25-67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or town) (County) (State) BALTO MD	
24. FUNERAL DIRECTOR C. T. EVANS				ADDRESS 8802 Hartford Rd		25a. REC'D BY REGISTRAR MAY 23 1967	
				25b. REGISTRAR'S SIGNATURE John Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

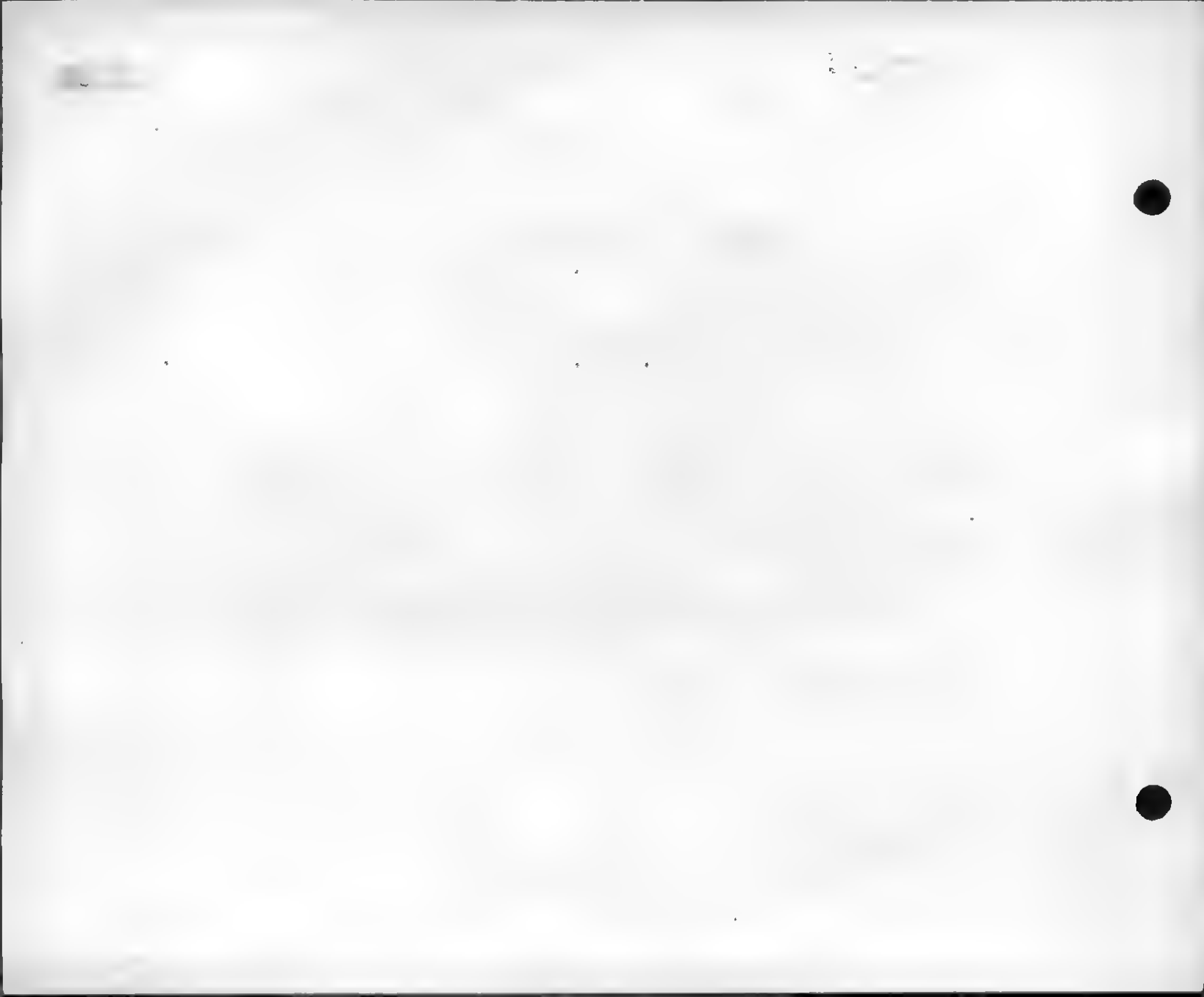
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06350

CERTIFICATE OF DEATH

100310

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 4 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shangri-La Nursing Home		d. STREET ADDRESS 4006 - 38th St.	
3 NAME OF DECEASED (Type or print) Frank R. Malzone		4 DATE OF DEATH 5-10-1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/20/1896
9 AGE (In years last birthday) 71 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (County & State, or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Malzone	
14. MOTHER'S MAIDEN NAME Margaret Dalton		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO 386-12-3621		17. INFORMANT Mrs. Mary Lila Malzone (above address)	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intractable Congestive Heart Failure (life) DUE TO (b) Old Myocardial Infarction DUE TO (c) ASCVD		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-10-1967 , to 5-10-1967 , that (I) (we) last saw the deceased alive on 5-10-1967 , and that death occurred at 9 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Cesar Valle Caverio		22b. DATE SIGNED 5-10-67	
22c. PHYSICIAN'S NAME (Type) CEsar VALLE CAVERIO		22d. ADDRESS 7634 Liberty Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/13/67	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR DATE 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

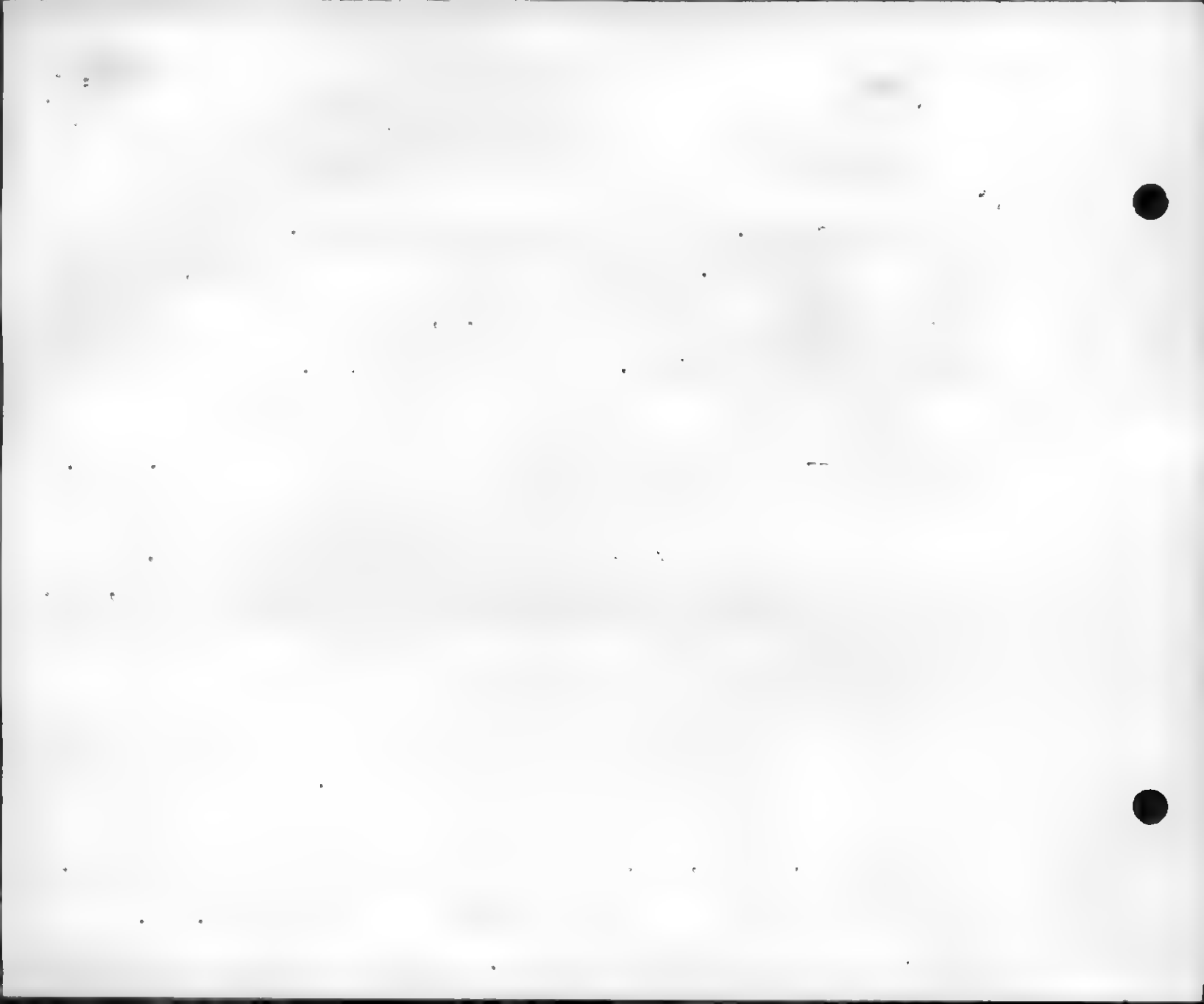
06351

06341

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c LENGTH OF STAY IN 1b Essex (21)	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2262 Monocacy Rd.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) GEORGE W. MANNER First Middle Last		4 DATE OF DEATH May 26, 1967 Month Day Year	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 5, 1901
9 AGE (In years lost birthday) 65 yrs	10a LSLAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk	10b KIND OF BUSINESS OR INDUSTRY Oil Co.	11 BIRTHPLACE (County & State, or foreign country) Baltimore, Md.
12 C TIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Agusta Manner	
14 MOTHER'S MAIDEN NAME Caroline Morecraft		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO 215 03 9093		17 INFORMANT Thelma Manner 2262 Monocacy Rd. Balto. 21 Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction, fatal 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive arteriosclerotic C.V.D., dur. 5yr. + DUE TO (c) Generalized arteriosclerosis, moderate, advanced, 5yrs. +			INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) no		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the doctor) attended the deceased from 1/18/63 , 19__, to 5/26/67 , 19__, that (I) (the doctor) saw the deceased alive on 5/24/67 , 19__, and that death occurred at 1 A.M. from causes and on the date stated above			
22a. SIGNATURE R.V. Rangle, M.D.		22b. DATE SIGNED 5/26/67	
22c. PHYSICIAN'S NAME (Type) R.V. Rangle, M.D.		22d. ADDRESS 2938 St. Paul St., Baltimore, Md. 18	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/29/67	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Co., Md.
24. FUNERAL DIRECTOR Brudzinski Funeral Home 1407 Eastern Ave.		25a. REC'D BY REGISTRAR DATE MAY 29 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

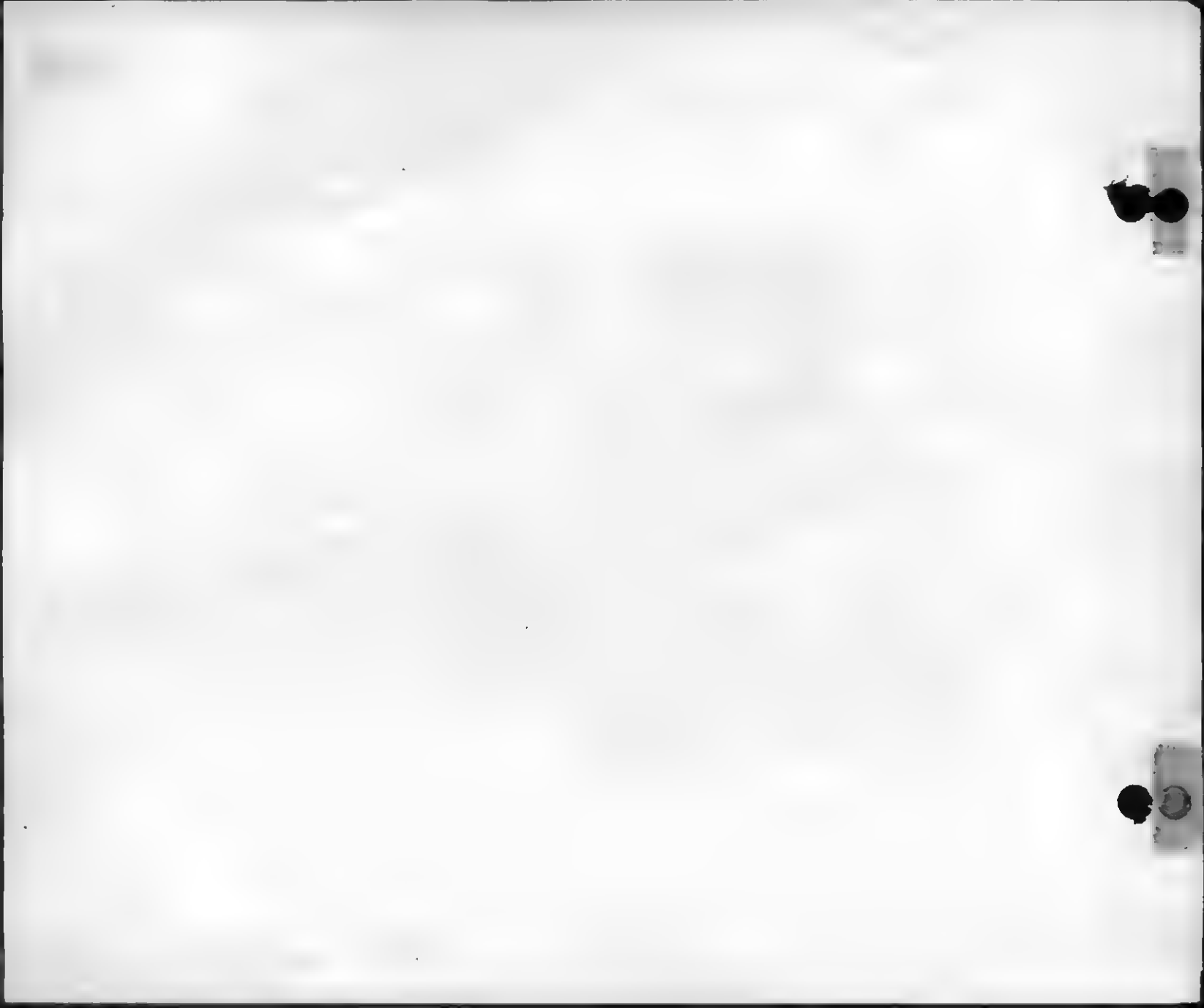


96352

CERTIFICATE OF DEATH

Reg. Dist. No. 96342

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>2203 Rockwell Rd.</u>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 23</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>3318 Fair Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle _____ Last <u>MARTIN</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-1889</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Lith.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Sprainia</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Serechkes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. _____	
INFORMANT <u>Mr. Andrew Sprainia</u>		Address <u>2203 Rockwell Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic C.V. disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>4/26</u> , 19 <u>67</u> , to <u>5/2</u> , 19 <u>67</u> . That I last saw the deceased alive on <u>5/1</u> , 19 <u>67</u> , and that death occurred at <u>7:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. C. Mac Laughlin</u>		ADDRESS (Street, city or town, state) <u>303 N. Rolling Rd.</u>	
PHYSICIAN'S NAME (Type) <u>Thelma A. Hoffman</u>		DATE <u>5/2/67</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-5-67</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) _____ (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thelma A. Hoffman</u>		24a. REC'D BY REGISTRAR <u>3218 Hudson St.</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>		DATE <u>MAY 8 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06353

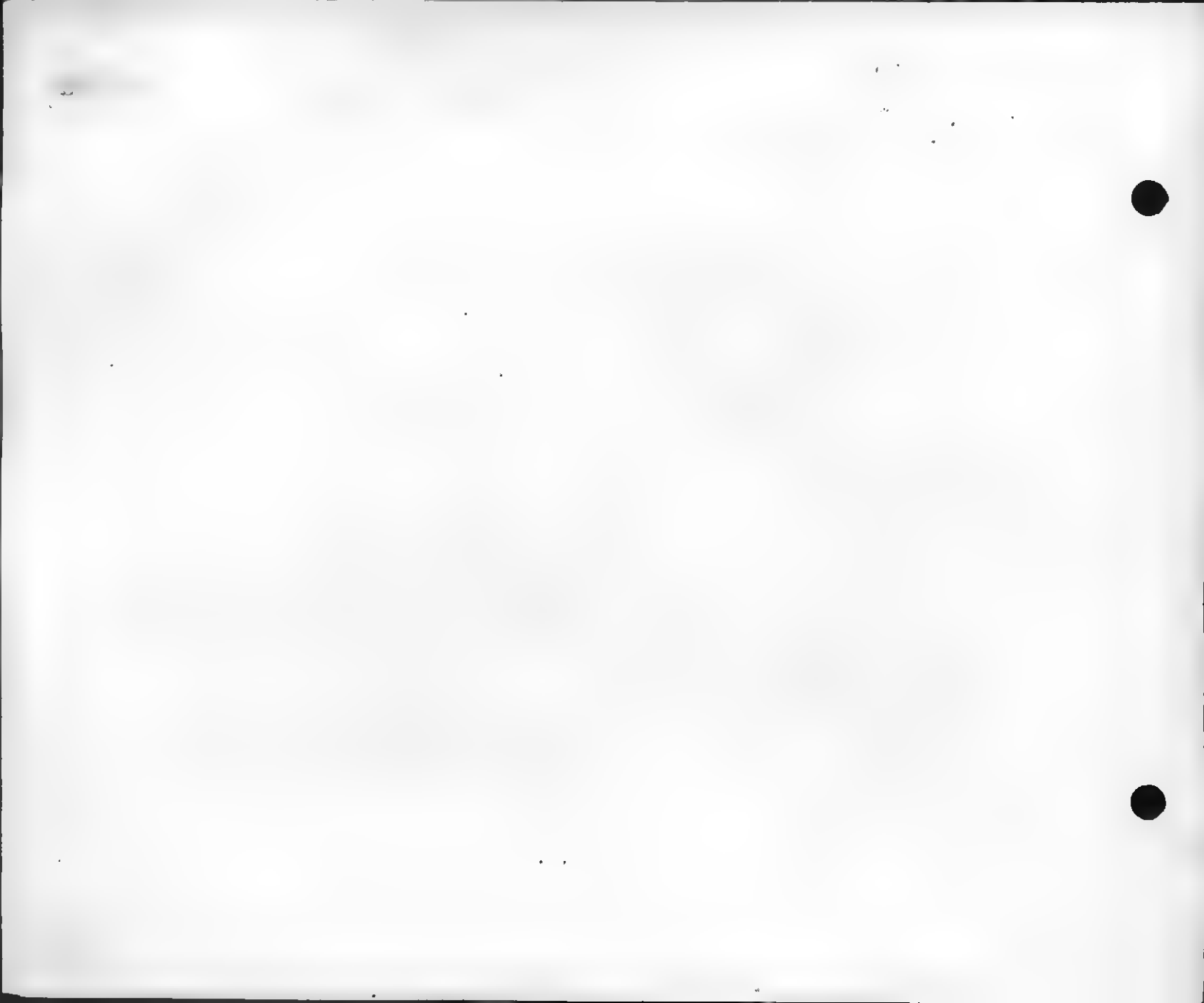
06343

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY (If in hospital, give date) 3 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 606 Stone Barn Road				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death on) a. STATE Maryland b. COUNTY BALTIMORE c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 606 Stone Barn Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDWARD LAWRENCE MC CLOSKEY				4. DATE OF DEATH Month May Day 25 Year 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 31, 1929	
9. AGE (In years last birthday) 37		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Financial Analyst		10b. KIND OF BUSINESS OR INDUSTRY Westinghouse Elec.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lawrence McCloskey		14. MOTHER'S MAIDEN NAME Edna Folger		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Anne McCloskey		Address same as 2-d		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 4200 DUE TO (c)	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED May 25, 1967	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 27, 1967		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Woodlawn, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Road Towson, Maryland 21204				25a. REC'D BY REGISTRAR MAY 29 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06354

CERTIFICATE OF DEATH

06344

1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>MD</u> b COUNTY <u>BALTO</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>		c LENGTH OF STAY IN TB <u>23 years</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9210 1/2 Hartford Rd</u>		e STREET ADDRESS <u>9210 1/2 Hartford Rd</u>	
3 NAME OF DECEASED (Type or print) <u>CARROLL</u> First <u>N.</u> Middle <u>M.</u> Last <u>McCready</u>		4 DATE OF DEATH Month <u>MAY</u> Day <u>12</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct 21-1903</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Printer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Letter Press</u>	9 AGE (In years last birthday) <u>63</u> yrs
11 BIRTHPLACE (County & State, or foreign country) <u>BALTO. MD</u>		12 CITIZEN OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>NORMAN McCready</u>		14 MOTHER'S MAIDEN NAME <u>ANN CARROLL</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>212-09-0463</u>	
17 INFORMANT <u>Annabelle Callis</u>		Address <u>Same</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic carcinoma generalized</u> <u>1963</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of colon</u> DUE TO (c) _____			INTERVA. BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>7/10/66</u> , 19 <u>66</u> , to <u>5/9</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>5/9</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> a.m., from causes and on the date stated above.			
22a SIGNATURE <u>Robert E. Martin</u>		22b DATE SIGNED <u>5/12/67</u>	
22c PHYSICIAN'S NAME (Type) <u>ROBERT E. MARTIN</u>		22d ADDRESS <u>3201 N. CHARLES ST</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>5-15-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Garden</u>	23d LOCATION (City or town) (County) (State) <u>Bel Air MD</u>
24 FUNERAL DIRECTOR <u>C. F. EVANS & SON</u>		25a REC'D BY REGISTRAR DATE <u>MAY 16 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06355

CERTIFICATE OF DEATH

06345

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GBMC.</u>		d. STREET ADDRESS <u>418 DONEGAL DRIVE</u> PATIENTS ADDRESS	
3 NAME OF DECEASED (Type or print) <u>EDNA</u> First Middle Last <u>MYRTLE McDONNELL</u>		4 DATE OF DEATH <u>5-2-67</u> Month Day Year <u>19 67</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-28 96</u> 9 AGE (In years lost birthday) <u>70</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>BALTO, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CALEB BOND</u>		14. MOTHER'S MAIDEN NAME <u>LENA Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>2-15-487841</u>	
17 INFORMANT <u>M. RICHARD McDONNELL</u> Address <u>418 DONEGAL DR.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> 31X DUE TO <u>cerebrovascular accident with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>probable intracerebral hemorrhage</u> (b) <u>30 hrs.</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (1) (this hospital) attended the deceased from <u>5-2</u> , 19 <u>67</u> , to <u>5-2</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>5-2</u> 19 <u>67</u> , and that death occurred at <u>3:15</u> AM, from causes and on the date stated above			
22a SIGNATURE <u>V.R. Batoyon</u>		22b DATE SIGNED <u>5-2-67</u>	
22c PHYSICIAN'S NAME (Type) <u>V. R. BATOYON</u>		22d ADDRESS <u>6701 N. Charles ST. Balto, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>5-2-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	23d LOCATION (City or Town) (County) (State) <u>Parkville Md.</u>
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>		25a. REC'D BY REGISTRAR <u>MAY 3 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>W. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

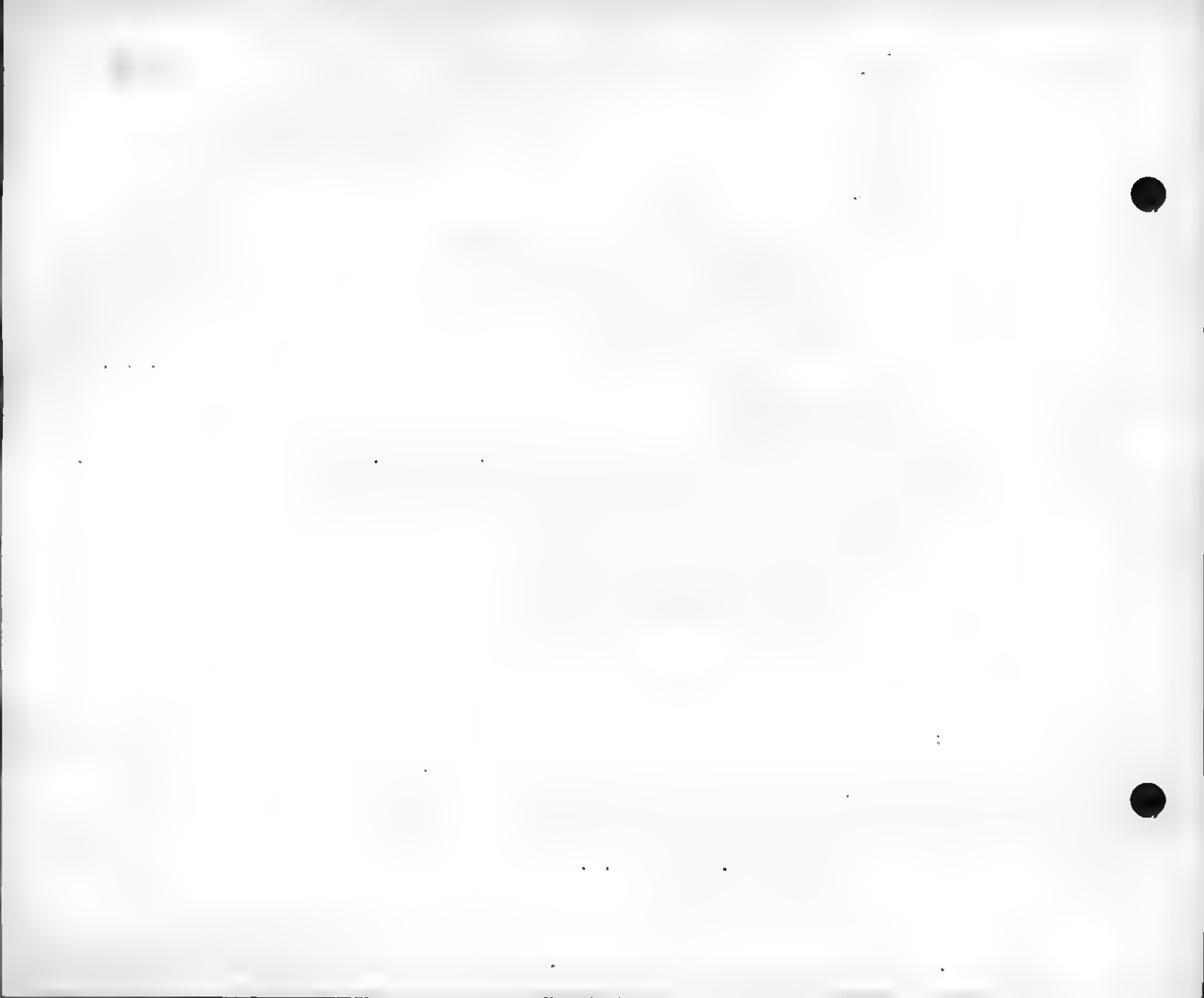
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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE b. STATE MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LOCH RAVEN RESEVOIR		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) About one-half mile from bridge		d. STREET ADDRESS 1 New Forrest Court	
3 NAME OF DECEASED (Type or print) Ollie SUE McIllyar		4 DATE OF DEATH Month 5 Day 8 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-18-21
9 AGE (in years last birthday) 45		10 IF UNDER 1 YEAR Months 8 Days 19 Hours 67	
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Dallas, Texas		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Maithias Armstrong		14. MOTHER'S MAIDEN NAME Eula Raines	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 415-26-5743	
17 INFORMANT Mr. James D. McIllyar		Address 1 New Forest Ct.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Drove car through guard rail and plunged into reservoir	
20c TIME OF DEATH Month, Day, Year Hour 3:57 pm 5 8 1967	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Reservoir	20f (City or town) (County) (State) Baltimore Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 5-9-67	
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b DATE THEREOF 5/11/67	23c NAME OF CEMETERY OR CREMATORY Greenmount Crematory	23d LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Wm. Cook-Brooks		25a. REC'D BY REGISTRAR MAY 10 1967	
ADDRESS Towson 1050 York Rd. 21204		25b. REGISTRAR'S SIGNATURE Charles Judge	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6247

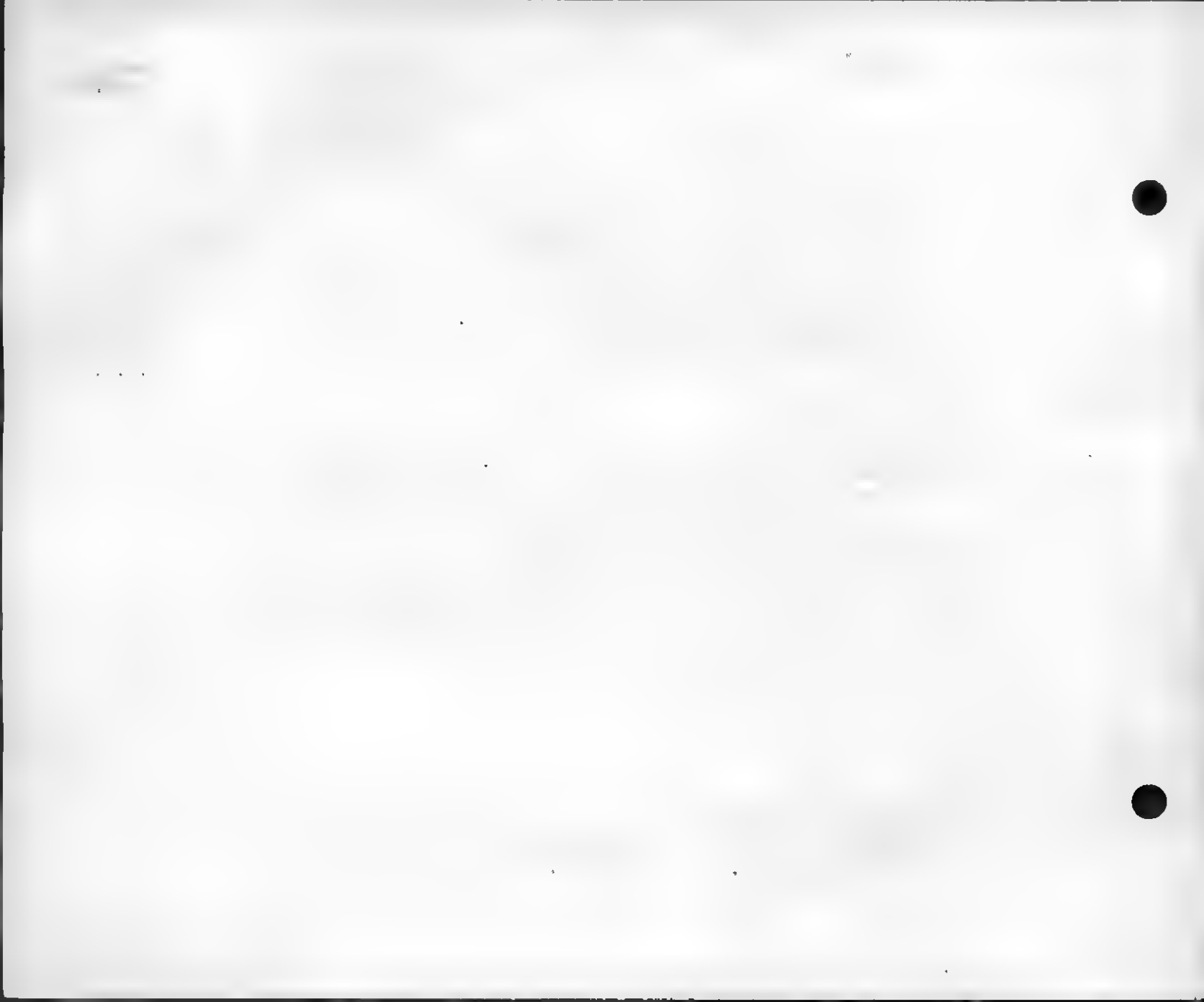
FOR STATE
HEALTH DEPT

06357

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Res. domicile before admission) a STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Texas		c LENGTH OF STAY IN 1b Years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Church Lane		d STREET ADDRESS Church Lane	
3. NAME OF DECEASED (Type or print) Roy Dean McMillan		4 DATE OF DEATH Month May Day 7 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 4, 1917
9 AGE (In years last birthday) 50 yrs		10 IF UNDER 1 YEAR Months 5 Days 7 Hours 19 Min 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b KIND OF BUSINESS OR INDUSTRY North Carolina	
11 BIRTHPLACE (State or foreign country) U.S.A.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Grover McMillan		14 MOTHER'S MAIDEN NAME Cora Moxley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO Mrs. Mary Edith McMillan Church Lane, Texas	
17 INFORMANT Mrs. Mary Edith McMillan		Address Church Lane, Texas	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY 4801 IMMEDIATE CAUSE (a) Coronary Occlusion S. S. S. DUE TO (b) Interval between onset and death DUE TO (c) Interval between onset and death			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour am 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		22. DATE SIGNED 5/7/67	
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		Address (Street, city, town, or county) Sparks, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 5/11/67	23c NAME OF CEMETERY OR CREMATORY Jessops Cemetery	23d LOCATION (City or Town) (County) (State) Sparks, Md.
24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204		25a RECEIVED BY REGISTRAR MAY 10 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

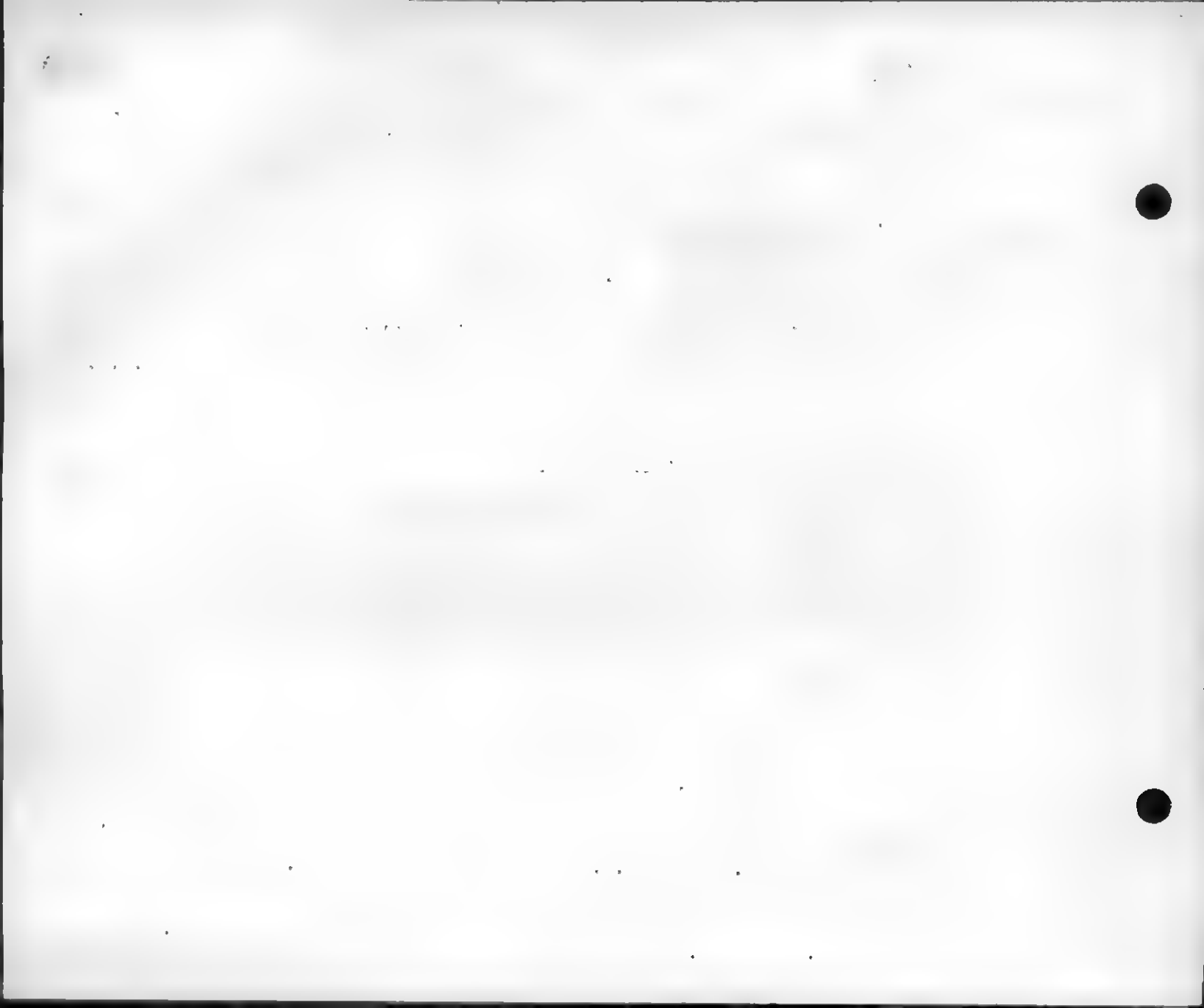
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06358

CERTIFICATE OF DEATH

06348

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY —	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c LENGTH OF STAY IN 1b Baltimore 21206	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital		e STREET ADDRESS 5000 Lodestone Way	
3. NAME OF DECEASED (Type or print) Margaret E. MEEHAN		4. DATE OF DEATH Month May Day 30 Year 19 67	
5 SEX female	6. COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 8 1893
9. AGE (In years last birthday) 73 YRS		10. BIRTHPLACE (County & State, or foreign country) Maryland	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11 BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Dieter	
14. MOTHER'S MAIDEN NAME Mary Streb		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 220-05-0844		17. INFORMANT Mr. William Meehan	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4500 General Arteriosclerosis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 67 , to May 30 , 19 67 , that (I) (we) last saw the deceased alive on May 30 , 19 67 , and that death occurred at 1a M, from causes on and on the date stated above.			
22a. SIGNATURE Ismael O. Jamora M.D.		22b. DATE SIGNED May 30, 1967	
22c PHYSICIAN'S NAME (Type) Ismael O. Jamora M.D.		22d ADDRESS 7620 York Rd. Towson 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF June 2, 1967	23c NAME OF CEMETERY OR CREMATORY Holy Redeemer	23d LOCATION (City or Town) (County) (State) Baltimore Md
24 FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd.		25a REC'D BY REGISTRAR DATE MAY 31 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06359

CERTIFICATE OF DEATH

06349

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson (rural)		c. LENGTH OF STAY IN 1b -21236	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 2 Henry Avenue	
3 NAME OF DECEASED (Type or print) First Middle Last Barbara J. Meise		4 DATE OF DEATH Month Day Year May 1, 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-15-01
9 AGE (In years last birthday) 65 yrs		10 F UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b KIND OF BUSINESS OR INDUSTRY Bush Co.	
11 BIRTHPLACE (County & State or foreign country) Baltimore, Md.		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Mohr		14. MOTHER'S MAIDEN NAME Elizabeth Kern	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 212-32-7314	
17. INFORMANT Mr Kenneth Meise		Address 2934 Edgewood Road #34	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that A (this hospital) attended the deceased from April 2, 1967 , to May 1, 1967 , that A (we) last saw the deceased alive on May 1, 1967 , and that death occurred at 2:15AM , from causes and on the date stated above.			
22a SIGNATURE M.S. Cockburn		22b DATE SIGNED May 1, 1967	
22c PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D.		22d ADDRESS 7620 York Rd., Towson, Md. 21204	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 5-4-1967	23c NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	23d LOCATION (City or Town) (County) (State) Baltimore, Co. Md.
24 FUNERAL DIRECTOR Larsen Funeral Home		25a REC'D BY REGISTRAR MAY 3 1967	
ADDRESS 7401 Belair Road		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY P.B.C.P. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ADELPHI MD				3. NAME OF DECEASED (Type or print) First RUBIN Middle MEDELSON Last MEDELSON			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GARDEN STATE HOS				e. STREET ADDRESS 2004, 8th ST				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month MAY Day 7 Year 1967		5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-21-85		9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR				10b. KIND OF BUSINESS OR INDUSTRY CLOTHING				11. BIRTHPLACE (County & State, or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? RUSSIA	
13. FATHER'S NAME ERIC MEDELSON						14. MOTHER'S MAIDEN NAME HANNAH MEDELSON					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 497-36-8462		17. INFORMANT SPRING GARDEN STATE HOS					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOE TO Pneumonia DOE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8-30- 19 62 to 5-7- 19 67 , that (I) (we) last saw the deceased alive on 5-7 19 67 , and that death occurred at 2 PM , from the causes and on the date stated above.											
22a. SIGNATURE Ricardo Ibanez				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 5-7-67			
22c. PHYSICIAN'S NAME (Type) RICARDO IBANEZ				22d. ADDRESS Spring Grove Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/9/1967		23c. NAME OF CEMETERY OR CREMATORY GEO. WASH. Cem.				23d. LOCATION (City, town or county) (State) HYATTSVILLE, MD			
24. FUNERAL DIRECTOR Healey Funeral Home				ADDRESS 4217 9th St. NW				25a. REC'D BY REGISTRAR MAY 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06361

CERTIFICATE OF DEATH

06251

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY in 1b 24 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3614 LYNDALE AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last GEORGE CHARLES MENZEL				4 DATE OF DEATH Month Day Year MAY 20, 1967			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/5/10	9 AGE (In years last birthday) 57 yrs	F UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. US. AL OCCUPATION (Give kind of work done during most of work life, even if retired) BOOK BINDING			10b. KIND OF BUSINESS OR INDUSTRY BUREAU OF ENGRAVING		11 BIRTHPLACE (County & State or foreign country) BALTIMORE, MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE A. MENZEL				14. MOTHER'S MAIDEN NAME FLORENCE WENZEL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WWII		16. SOCIAL SECURITY NO 214 01 41 57		17 INFORMANT Address CLINICAL RECORDS, VAH, FT. HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, LEFT SIDE, WITH DUE TO (b) METASTASES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)						INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						9. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/26 , 19 67 , to 5/20 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/20/67 , 19 67 , and that death occurred at 3:45M , from causes and on the date stated above							
22a. SIGNATURE <i>Paulino D. Deocampo</i>				P. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 5/21/67	
22c. PHYSICIAN'S NAME (Type) PAULINO D. DEOCAMPO, M.D.				22d. ADDRESS VA Hospital, Fort Howard, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/24/67		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Schimunek Funeral Home				25a. REC'D BY REGISTRAR DATE MAY 23 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06362

CERTIFICATE OF DEATH

06352

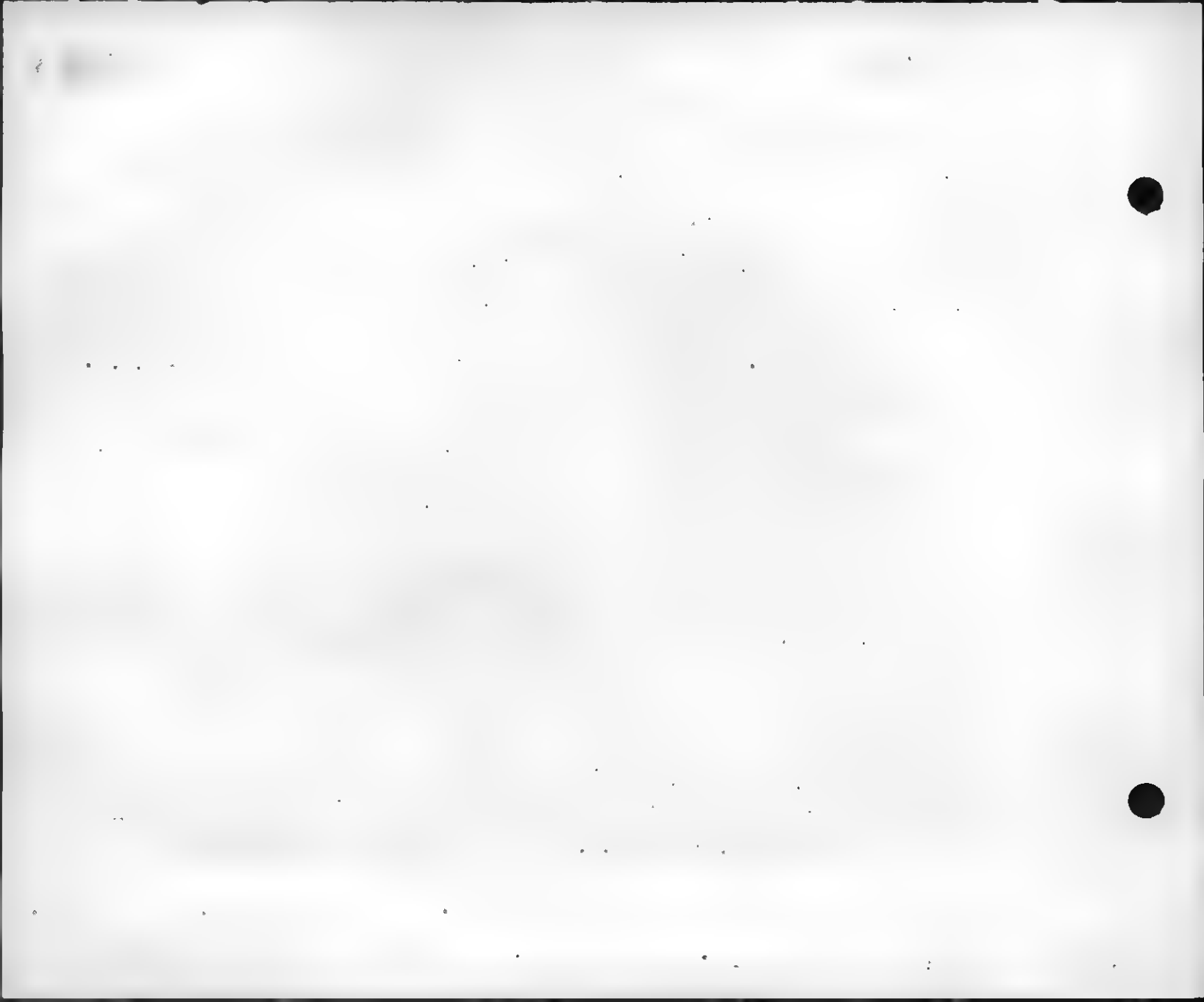
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN TB 2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3. DATE OF DEATH Month May Day 11 Year 1967	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. STREET ADDRESS 900 Cathedral Street	
3. NAME OF DECEASED (Type or print) MORRIS First — Middle — Last MICHAEL		4. DATE OF DEATH Month May Day 11 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/26/94
9. AGE (In years, last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Clothing Industry	
11. BIRTHPLACE (County & State or foreign country) Hudson, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Michael		14. MOTHER'S MAIDEN NAME Sarah Litsitz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-1		16. SOCIAL SECURITY NO. 215 01 56 30	
17. INFORMANT Clinical Rcds. VA Hospital, Fort Howard, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA XXX Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) METASTATIC ADENOCARCINOMA LUNGS, LIVER, ADRENALS AND RIBS XXX (c) ARTERIOSCLEROSIS, GENERALIZED		INTERVAL BETWEEN ONSET AND DEATH Recent	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SURGICAL ABSENCE RIGHT COLON (ADENOCARCINOMA)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a.m. 19 p.m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 4 (this hospital) attended the deceased from May 9 , 19 67 , to May 11 , 19 67 that 4 (we) last saw the deceased alive on May 11 , 19 67 , and that death occurred at 12:20 PM from causes and on the date stated above.			
22a. SIGNATURE Milton Ginsberg		22b. DATE SIGNED 5/12/67	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M.D.		22d. ADDRESS VA Hospital, Fort Howard, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/15/67	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR ZAMINO FUNERAL HOME		25a. REGD. BY REGISTRAR 251 S. Conking St. Balto. Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 15 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Baltimore		Baltimore		23 days		Maryland		Cecil		Rural	
3. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Spring Grove State Hospital						None					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
Mattie Blanche Mitchell								May 12 1967			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White				5-28-74		92 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife Ret. Own Home								West Virginia		Floyd Co. U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
Marion Summer				Amy Ellen Haley							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				220-18-7751		Records Spring Grove State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio vascular Disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Hip fracture (left) and generalized arteriosclerosis											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from 4-17-67, 19, to May 12, 1967, that (X) (we) last saw the deceased alive on May 12, 1967, and that death occurred at 4:05 PM, from the causes and on the date stated above.											
22a. SIGNATURE				22b. DATE SIGNED							
Anthony J. Young, M.D.				5-12-67							
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS							
Spring Grove State Hospital				Baltimore, Maryland 21228							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
Burial		5-15-1967		Brookview Cem.		Rising Sun, Md.					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Richard L. Goode				MAY 16 1967				Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

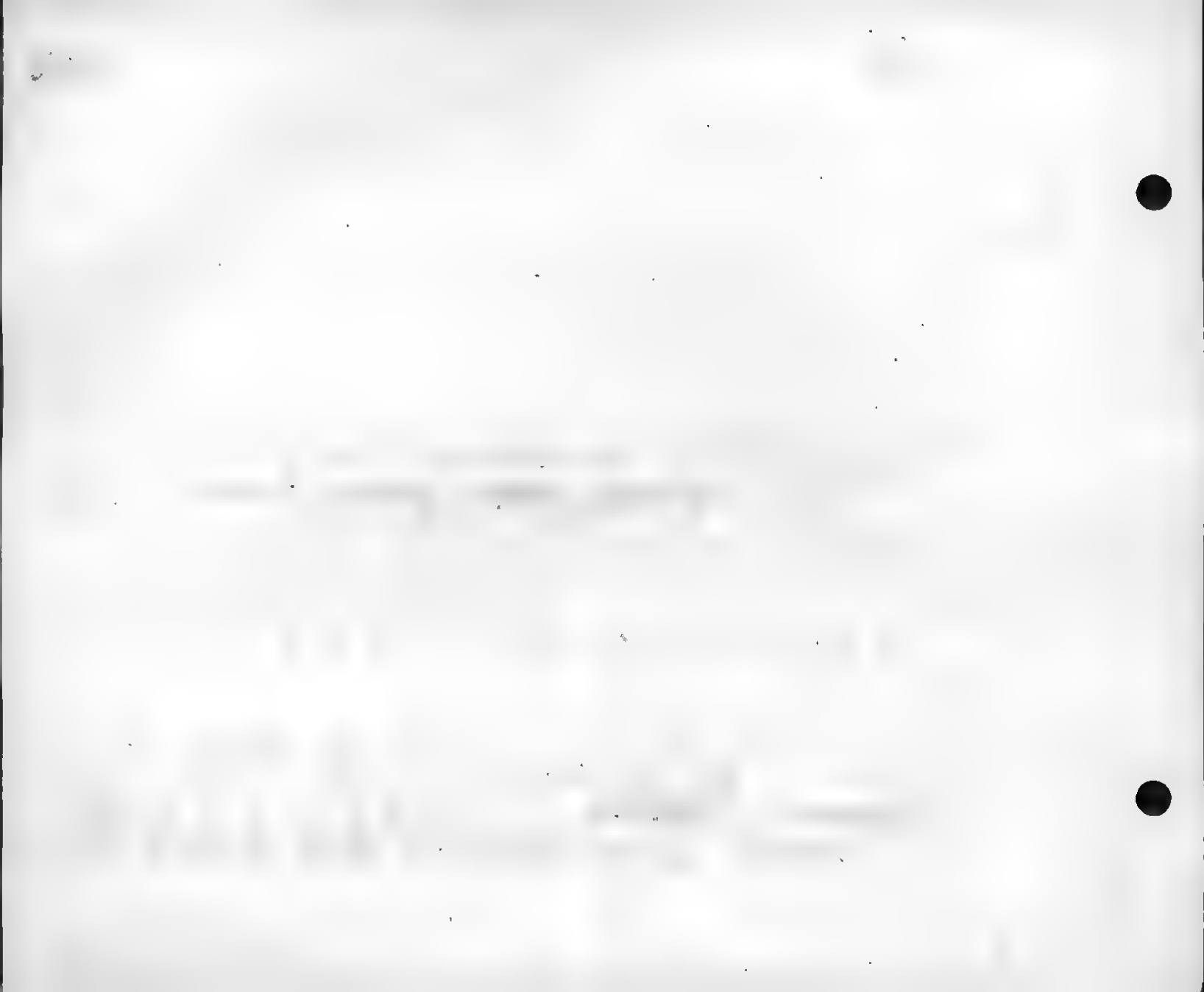
MD
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06364

CERTIFICATE OF DEATH

06254

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3711 Washington Ave</u>		d. STREET ADDRESS <u>3711 Washington Ave</u>	
3. NAME OF DECEASED (Type or print) <u>John Randolph Moore</u>		4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-19-1902</u>
9. AGE (in years last birthday) <u>64 yrs</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Mins <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles T. Moore</u>		14. MOTHER'S MAIDEN NAME <u>De Lacy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-03-6228</u>	
17. INFORMANT <u>Jeanette F. Moore - Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HEMIPLEGIA, RIGHT DUE TO OLD CVA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JULY, 1957</u> to <u>MAY 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAY 14, 1967</u> , and that death occurred at <u>10 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Marvin Goldstein</u>		22b. DATE SIGNED <u>5/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN GOLDSTEIN</u>		22d. ADDRESS <u>6001 PARK HEIGHTS AVE. 21215</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5-19-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md</u>
24. FUNERAL DIRECTOR <u>Ellsworth Armbrast</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 22 1967</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16255

06365

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2430 SMITH AVE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>2430 Smith Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First Last Middle <u>MORGAN</u>		4. DATE OF DEATH Month Day Year <u>MAY 20 1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOT KNOWN</u>
9. AGE (In years last birthday) <u>75</u> yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>NOT KNOWN</u>		14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>EDWARD PERSKIE - SAME</u>	
17. INFORMANT <u>EDWARD PERSKIE - SAME</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>congestive Heart Failure</u> DUE TO (b) <u>H A S H D</u> DUE TO (c) <u>H A S H D</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 1 week</u> <u>7 years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> , 19 <u>67</u> , to <u>5/20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/20</u> , 19 <u>67</u> , and that death occurred at <u>9A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>5/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS <u>4000 W Northern Parkway</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>MAY 20, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WASH. BLVD</u>	23d. LOCATION (City, town or county) (State) <u>BALTO MD</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>SILVAN S. LEWIS + SON</u>		25a. REC'D BY REGISTRAR <u>MAY 23 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06366

CERTIFICATE OF DEATH

06256

1 PLACE OF DEATH a COUNTY BALTIMORE b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before entry) a STATE MARYLAND b COUNTY BALTIMORE	
c. LENGTH OF STAY IN 1b 53 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 7201 Belair Rd	
3 NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last MORRIS		4 DATE OF DEATH Month MAY Day 26 Year 19 67	
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 21, 1894
9 AGE (In years - last birthday) 73 yrs		10. UNDER 1 YEAR Months Days 11. UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10b. KIND OF BUSINESS OR INDUSTRY TAXICAB	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY MORRIS		14. MOTHER'S MAIDEN NAME BARBARA SACHS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. co.) YES WW I		16. SOCIAL SECURITY NO. 217 03 43 39	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COR PULMONALE 5020 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC BRONCHITIS AND PULMONARY EMPHYSEMA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 4/3/67 , 19__, to 5/26/67 , 19__, that (I) (we) last saw the deceased alive on 5/26/67 , 19__, and that death occurred at 5:45AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Peter V. Juvan</i>		22b. DATE SIGNED 5/26/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/29/67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR <i>Joseph N. Zannone</i>		25a. REC'D BY REGISTRAR MAY 28 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



1

MD 1-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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06367

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06357

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>411 BLOOMSBURY AVE</u>				d. STREET ADDRESS <u>411 BLOOMSBURY AVE</u>			
3. NAME OF DECEASED (Type or print) <u>FRANCES E. MORSBERGER</u>				4. DATE OF DEATH Month <u>5</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/7/97</u>	9. AGE (in years last birthday) <u>70</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret red) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>EDW. WM. MORSBERGER</u>			
14. MOTHER'S MAIDEN NAME <u>MARK J. ESPEY</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>EDITH T. MORSBERGER</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-vascular Disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>10 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1949</u> to <u>May 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 28, 1967</u> , and that death occurred at <u>6:30 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Wilmer K. Gallagher, M.D.</u>				22b. DATE SIGNED <u>May 29, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher, M.D.</u>	
22d. ADDRESS <u>6204 Frederick Ave. Baltimore 28 Md.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
23b. DATE THEREOF <u>5/29/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		23d. LOCATION (City or town) (County) (State) <u>BALTO MD</u>		24. FUNERAL DIRECTOR <u>E.S. MACIVABB</u>	
25a. REC'D BY REGISTRAR <u>MAI 31 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06368

CERTIFICATE OF DEATH

06358

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville, Md. (21093)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Balto. Medical Center		d. STREET ADDRESS 1512 Riderwood Lutherville	
3 NAME OF DECEASED (Type or print) Clarence Charles Nash		4 DATE OF DEATH 5 15 19 67	
5 SEX Male	6. COLOR OR RACE CAU.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/20/12
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire Chief		9b. KIND OF BUSINESS OR INDUSTRY BALTO. COUNTY	9c. BIRTHPLACE (County & State, or foreign country) Balto. Md.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire Chief		10b. KIND OF BUSINESS OR INDUSTRY BALTO. COUNTY	
11. BIRTHPLACE (County & State, or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Leroy Nash		14. MOTHER'S MAIDEN NAME DORA. T. Sheeler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UN KNOWN		16. SOCIAL SECURITY NO 218-05-0895	
17. INFORMANT UN KNOWN		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Atherosclerotic cardiovascular disease DUE TO (b) 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 4221 DUE TO (b) 4221 DUE TO (c) 4221			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sleus and early peritonitis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March , 19 67 , to 5/15 , 19 67 , that (I) (we) last saw the deceased alive on 5/15 , 19 67 , and that death occurred at 6:30 P.M. , from causes and on the date stated above			
22a. SIGNATURE Derek A Bruce		22b. DATE SIGNED 5/16/67	
22c. PHYSICIAN'S NAME (Type) DEREK A BRUCE		22d. ADDRESS G.D.M.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-18-67	23c. NAME OF CEMETERY OR CREMATORY POPLAR GROVE CEM.	23d. LOCATION (City or Town) (County) (State) COCKEYSVILLE MD.
24. FUNERAL DIRECTOR John Burns Son's		25a. REC'D BY REGISTRAR MAY 22 1967	
ADDRESS TOWSON, Md.		25b. REGISTRAR'S SIGNATURE John Burns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PEDESTAL STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06359

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Towson

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Bendix Radio, Joppa Rd.

2. USUAL RESIDENCE Where deceased lived, if institution Residence before admission

e. STREET ADDRESS b. COUNTY

Md.

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Baltimore

d. STREET ADDRESS

4591 St. Georges Ave.

a. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)

ROBERT

BRUCE

NEELY

5. SEX

Male

C

6. COLOR OR RACE

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

9/12/09

9. AGE (In years last birthday) 57 yrs. 11 months 11 days 1967

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Porter

10b. KNOWN BUSINESS OR INDUSTRY

Communications

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Weeler Neely

14. MOTHER'S MAIDEN NAME

Millie Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of service)

Yes

WW II

110 10 1942

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Myocardial Infarction

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Arteriosclerotic Cardiovascular Disease

5 years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

William A. Pillsbury

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

May 11, 1967

EXAMINER'S NAME (Type)

William A. Pillsbury

Address Timonium, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country)

(State)

BURIAL 5/14/67

5/14/67

St. Vernon Presbyterian Rowan Co. N. Carolina

23. FUNERAL DIRECTOR

ADDRESS Church Coll.

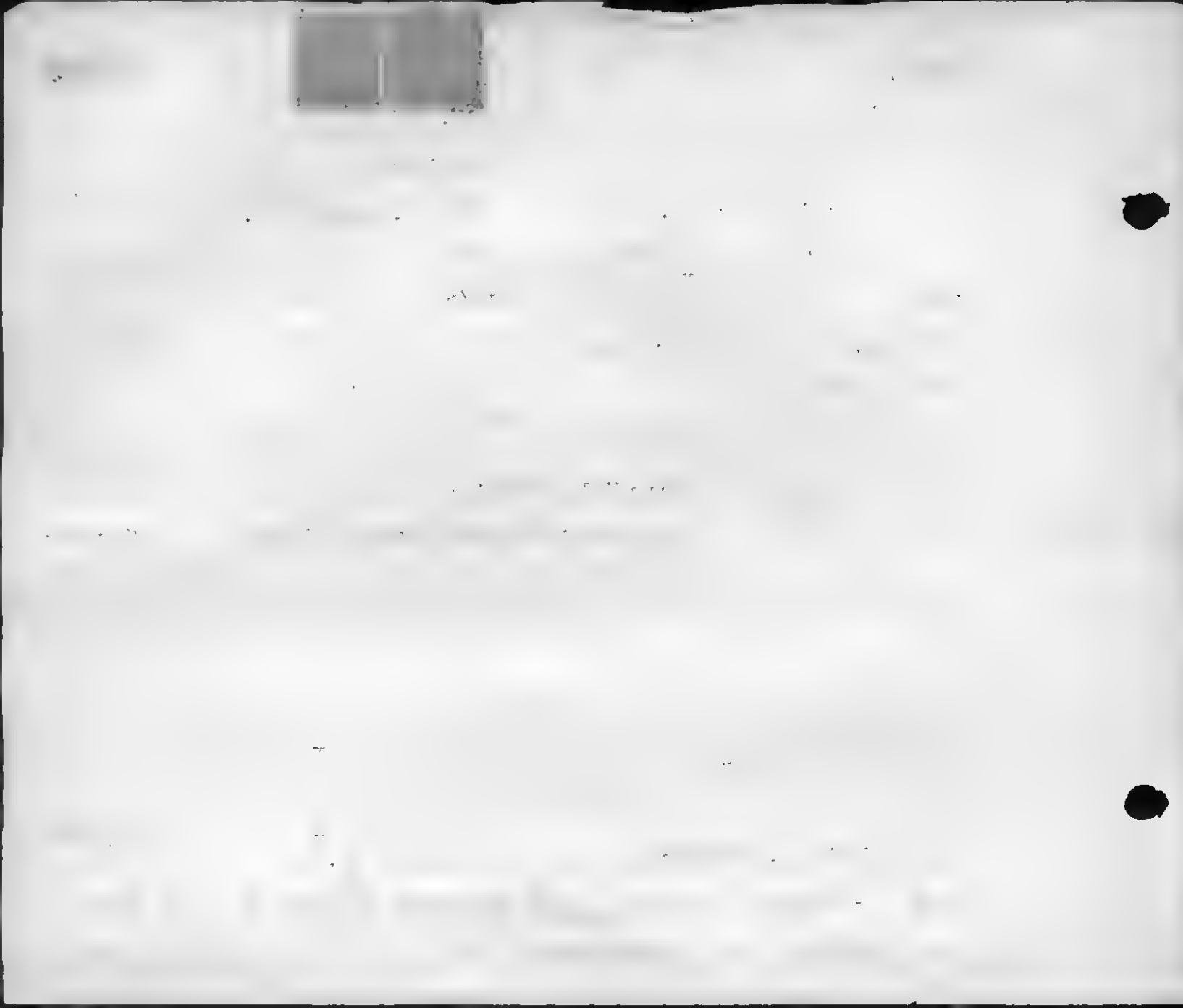
24. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Charles E. Johnson 8521 Loch Raven Blvd. DATE MAY 15 1967 Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted with n 2 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.



2 1 A

FOR STATE HEALTH DEPT. (M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

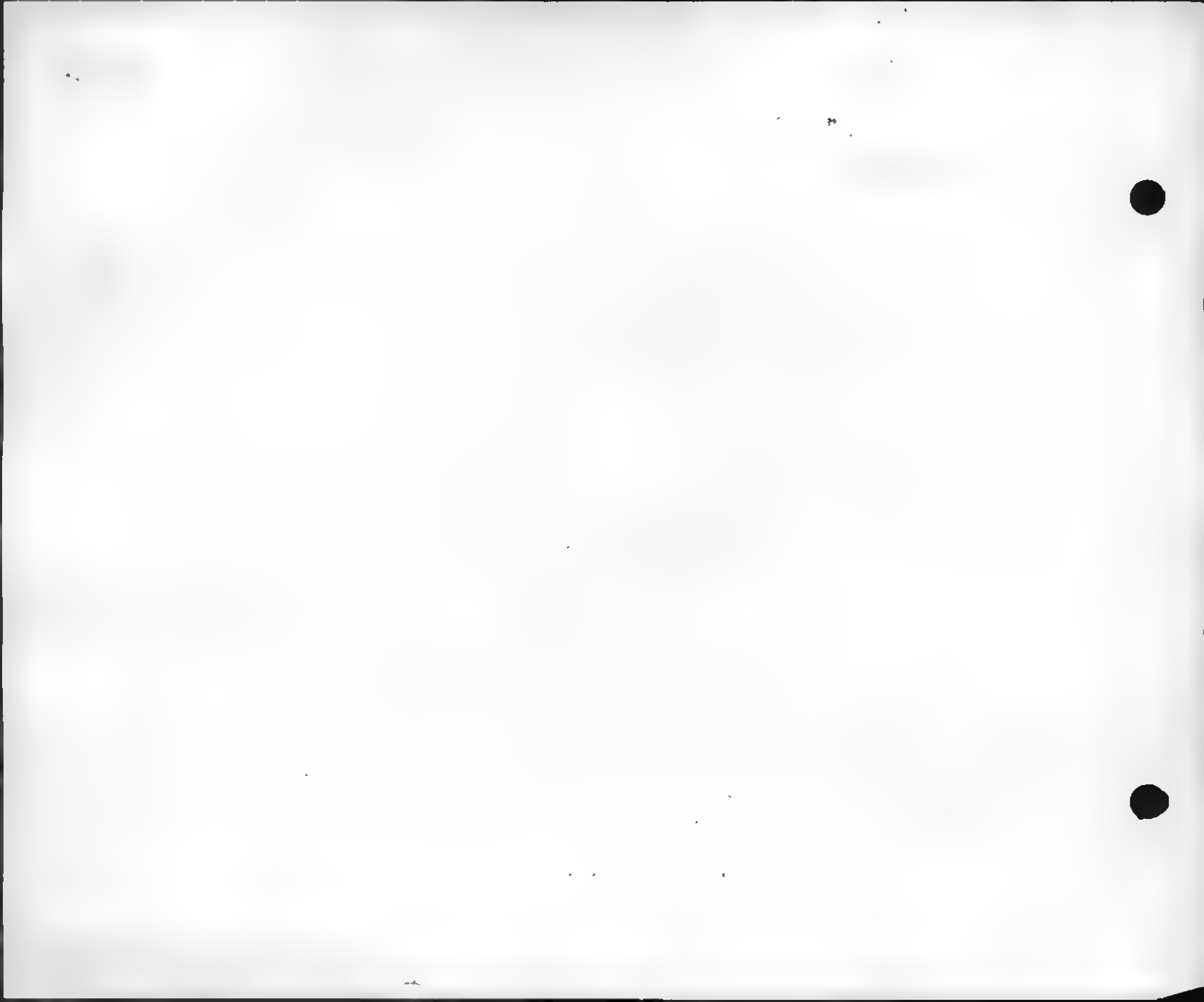
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06370

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06360

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. LENGTH OF STAY IN IT Lifetime			
d. NAME OF F.A. OR INSTITUTION (If not in hospital, give street address) 1118 Sulphur Spring Road 21227				d. STREET ADDRESS 1118 Sulphur Spring Road			
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH ELLEN NICHOLS				4. DATE OF DEATH Month Day Year May 20 19 67			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 25, 1912	9. AGE (in years last birthday) 55 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian			10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.		11. BIRTHPLACE (State or foreign country) Arbutus, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henson Garrett				14. MOTHER'S MAIDEN NAME Margaret Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO 214-18-6456		17. INFORMANT Mrs. Vivian Schofield Address 5211 Addison Rd N.E. Washington, D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease associated 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) with diabetes mellitus DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.			CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street city, town, or county) 5-22-67				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/25/67		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION (City or town) (County) (State) Arbutus Balto Co Md	
24. FUNERAL DIRECTOR Herbert E. Nutter 3035 W. North Ave				25a. REC'D BY REGISTRAR DATE MAY 23 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06371

CERTIFICATE OF DEATH

06361

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
c. LENGTH OF STAY IN IL 54 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 2306 26th AVALON AVENUE	
3 NAME OF DECEASED (Type or print) First CHARLES Middle WMI Last NUTT		4 DATE OF DEATH Month MAY Day 28 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/28/92
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CALTO, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR NUTT		14. MOTHER'S MAIDEN NAME EMALINE LEYLAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WMI		16. SOCIAL SECURITY NO 111 12 23 86	
17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 151X CARCINOMA OF STOMACH DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) ARTERIOSCLEROTIC HEART DISEASE AND CHRONIC PYELONEPHRITIS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/4/67 , 19 67 to 5/28 , 19 67 that (I) (we) last saw the deceased alive on 5/28 , 19 67 , and that death occurred at 5/28 , 19 67 , from causes and on the date stated above.			
22a. SIGNATURE John D. Talbert		22b. DATE SIGNED 5/28/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d. ADDRESS VA HOSPITAL FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 6-1-67	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cat	23d. LOCATION (City or town) (County) (State) Baltimore
24. FUNERAL DIRECTOR ELROY WILSON 1000 Brantley Ave. Balto. Md.		25a. REC'D BY REGISTRAR MAY 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Jones			

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TO HONORARY OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

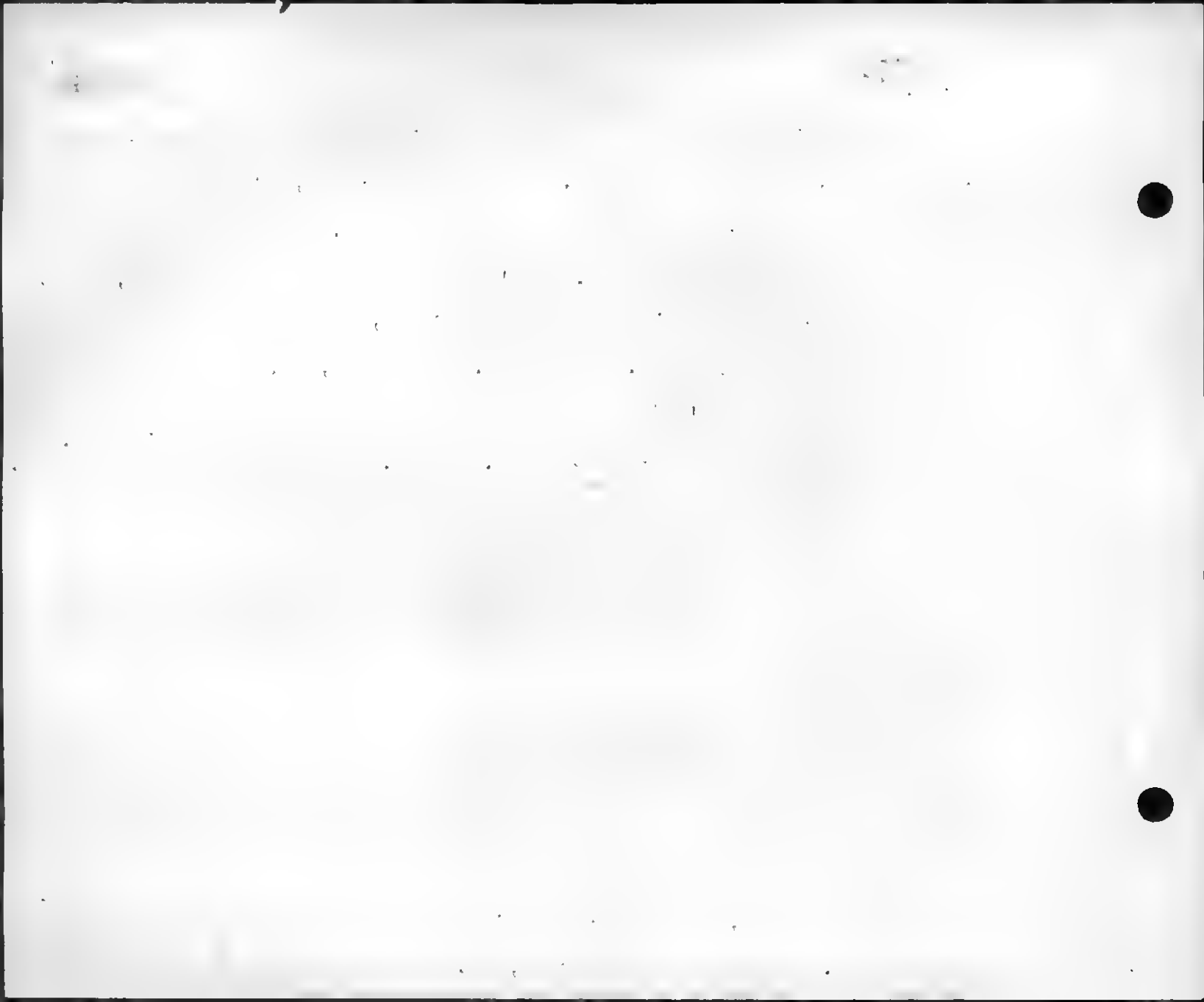
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06372

CERTIFICATE OF DEATH

06362

| | | | |
|--|--|--|--|
| 1 PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore Highlands | | c. LENGTH OF STAY IN 1b
3 Mos. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
4048 Mc Dowell Lane | | e. STREET ADDRESS
4107 Oak Rd. | |
| 3. NAME OF DECEASED
(Type or print) Thomas W. O'Brien | | 4 DATE OF DEATH
Month May Day 11 Year 19 67 | |
| 5 SEX
Male | 6. COLOR OR RACE
White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
August 19, 1897 |
| 9 AGE (In years last birthday) 69 yrs | | 10 IF UNDER 1 YEAR
Months 11 Days 19 Hours 67 Min | |
| 10a. OCCUPATION (Give kind of work done during most of working life, even if retired)
Cable Splicer (Ret) | | 10b. KIND OF BUSINESS OR INDUSTRY
Balto. Gas & Elec. Frederick, Md. | |
| 11 BIRTHPLACE (County & State, or foreign country)
USA | | 12 CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
O'Brien | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) None | | 16 SOCIAL SECURITY NO
212-05-5967 | |
| 17. INFORMANT
Mrs. Jane C. Denney (daughter) | | Address 307 Penna. Ave Elkton, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatous
DUE TO (b) Primary C.A. of Lung.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Nov 11 , 19 64 to 5/11 , 19 67 , that (I) (we) last saw the deceased alive on 5/11 , 19 67 , and that death occurred at 1:45 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
E.M. RAMOS M.D. | | 22b. DATE SIGNED
5/12/67 | |
| 22c. PHYSICIAN'S NAME (Type)
E.M. RAMOS M.D. | | 22d. ADDRESS
3927 Annapolis Rd Balt 27 | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
May 13, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | 23d. LOCATION (City or Town) (County) (State)
Brooklyn RD Maryland |
| 24 FUNERAL DIRECTOR
Richard V. Singleton Glen Burnie, Md. | | 25a. REC'D BY REGISTRAR
Charles Judge | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE
MAY 15 1967 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

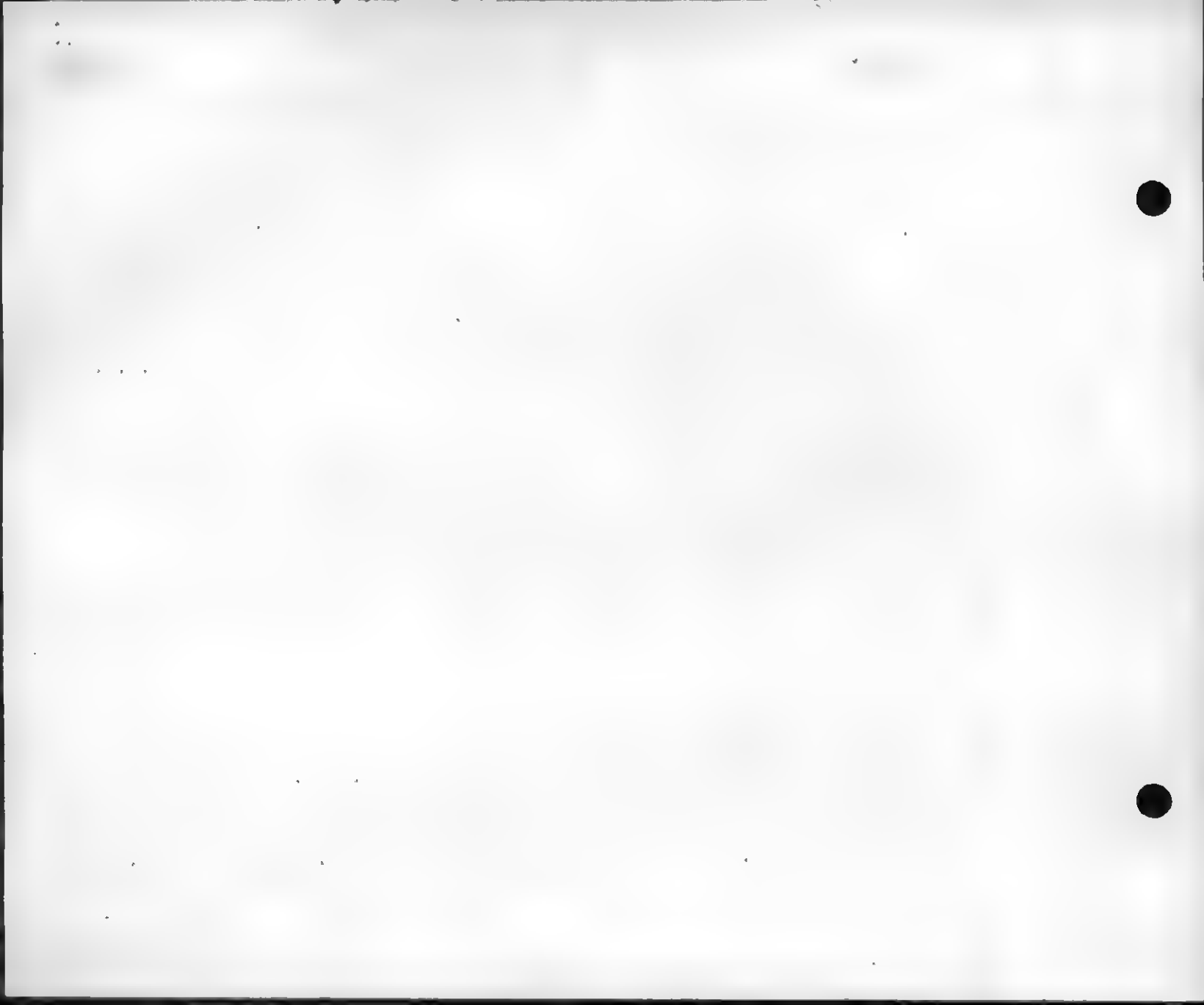
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06373

CERTIFICATE OF DEATH

DE-53

| | | | |
|---|---|--|--|
| 1 PLACE OF DEATH
a COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c LENGTH OF STAY IN 1b
Baltimore 21234 | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | d STREET ADDRESS
3003 Lavender Ave. | |
| 3. NAME OF DECEASED (Type or print)
First Orrie Middle Wilkins Last Oldland | | 4. DATE OF DEATH
Month May Day 31 Year 1967 | |
| 5 SEX
male | 6 COLOR OR RACE
white | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
Aug. 23 1898 |
| 9 AGE (In years last birthday)
68 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | |
| 10b KIND OF BUSINESS OR INDUSTRY
Coal Mine | | 11 BIRTHPLACE (County & State, or foreign country)
Penna. | |
| 12 CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13 FATHER'S NAME
Walter Oldland | |
| 14 MOTHER'S MAIDEN NAME
Ella ? | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Mrs Rose Oldland 3003 Lavender Avenue | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from May 30 , 19 67 to May 31 , 19 67 , that (I) (we) last saw the deceased alive on May 31 , 19 67 , and that death occurred at 5:35 PM from causes and on the date stated above | | | |
| 22a. SIGNATURE
Nelson S. de la Paz | | 22b. DATE SIGNED
May 31 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Nelson S. de la Paz | | 22d. ADDRESS
7620 York Rd. Baltimore, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
6-3-1967 | 23c. NAME OF CEMETERY OR CREMATORY
Laurel Hill Cemetery | 23d. LOCATION (City or Town) (County) (State)
Uniontown, Penna. |
| 24 FUNERAL DIRECTOR
Lassahn Funeral Home 7401 Belair Road | | 25a. REC'D BY REGISTRAR
DATE JUN 5 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

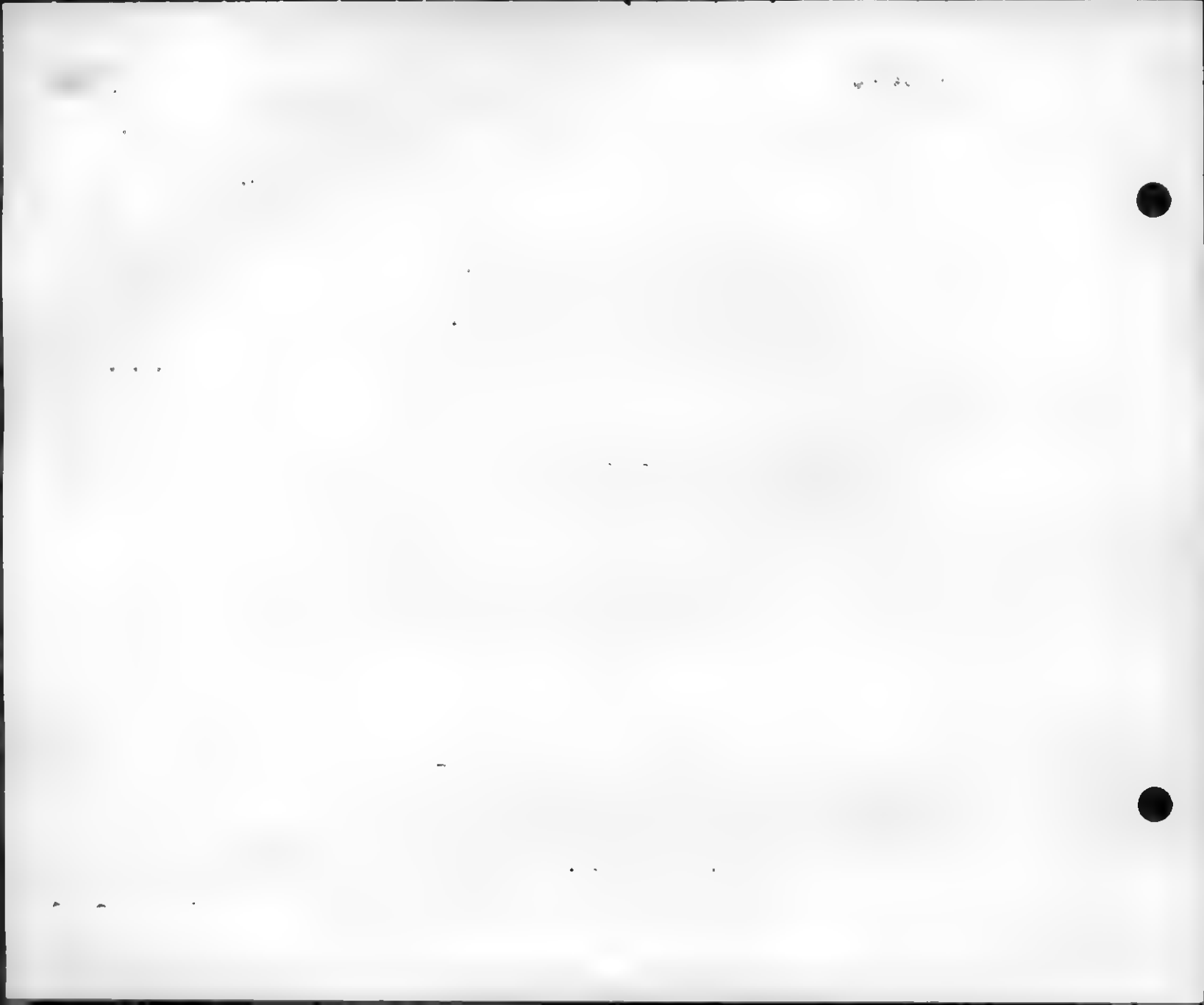
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06374

06264

| | | | |
|---|---------------------------------|---|--|
| 1 PLACE OF DEATH
a COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE Maryland b COUNTY Balto. | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c LENGTH OF STAY IN 1b
6mth7dys | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Spring Grove State Hospital | | d. STREET ADDRESS
3023 Second Avenue | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print)
First Middle Last
Emma Frances O'Mara | | 4 DATE OF DEATH
Month Day Year
May 24 1967 | |
| 5 SEX
Female | 6 COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 14, 1889 |
| 9 AGE (In years last birthday)
78 yrs | | 10. IF UNDER 1 YEAR
Months Days hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
House Wife | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13 FATHER'S NAME
Edmund Bry 44 | | 14. MOTHER'S MAIDEN NAME
Anna Ambrose | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes give war or dates of service) | | 16 SOCIAL SECURITY NO.
212-03-0945 | |
| 17. INFORMANT
Records: Spring Grove State Hospital | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Suppurative bronchopneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c) | | INTERVAL BETWEEN ONSET AND DEATH
3 weeks | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Decubitus ulcer | | 19 WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that it (this hospital) attended the deceased from 11-17-66 , 19 66 , to May 24 , 19 67 , that it (we) last saw the deceased alive on 19 , and that death occurred at 19 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Anthony J. Young, M.D. | | 22b. DATE SIGNED
5-24-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | 22d. ADDRESS
Spring Grove State Hospital
Baltimore, Maryland 21228 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
5-27-1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | 23d. LOCATION (City or town) (County) (State)
BALTO Md | |
| 24 FUNERAL DIRECTOR
C.F. EVANS & Son | | 25a. REC'D BY REGISTRAR
8802 HAROLD Rd | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE MAY 29 1967 | |



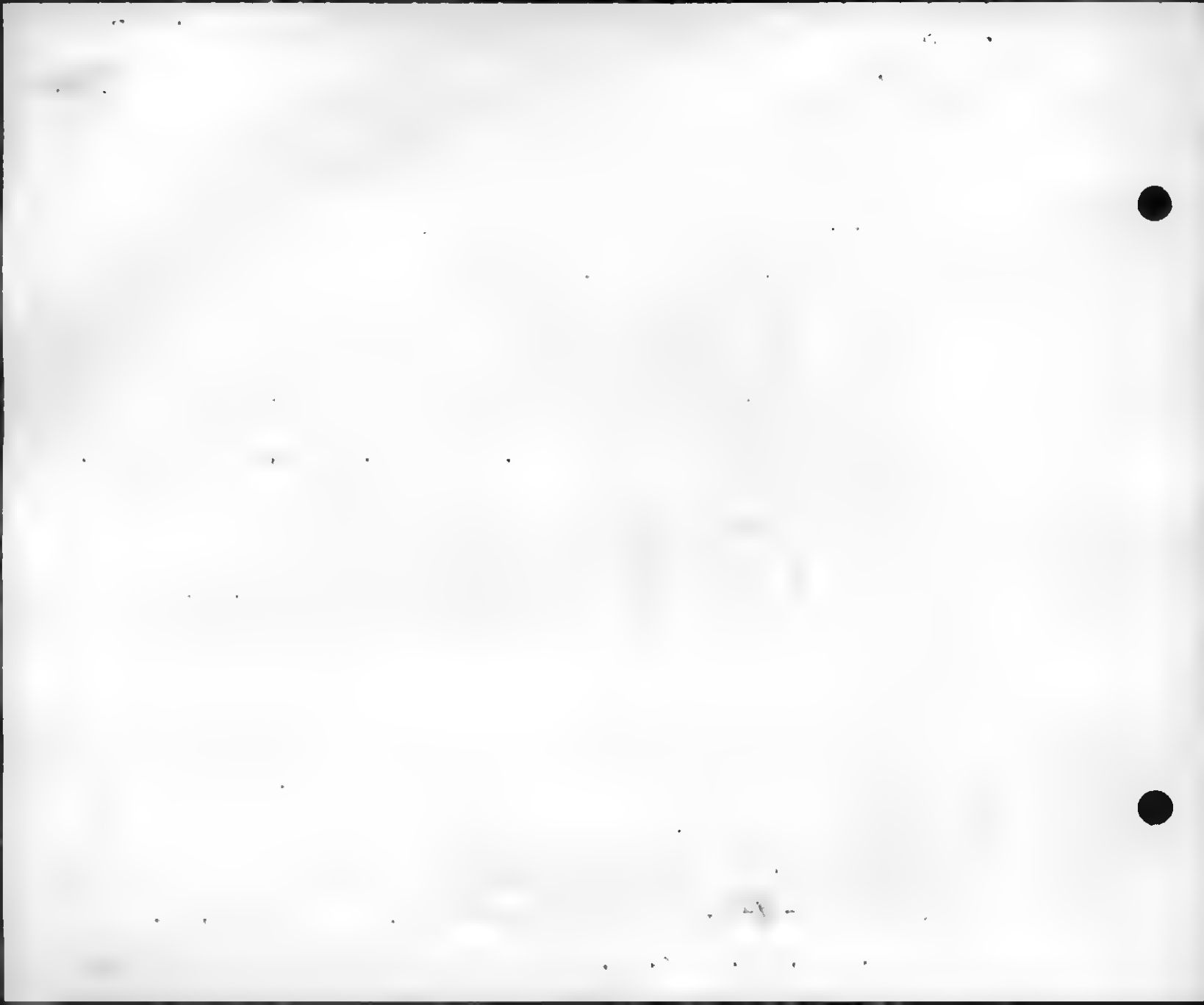
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1-66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--------------------------------------|--|---|--|---|--|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission)
a. STATE Maryland b. COUNTY | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21234 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | | | | | d. STREET ADDRESS
8415 Hallmark Circle | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED
(Type or print)
First Middle Last
Teresa A. Panico | | | | | | 4. DATE OF DEATH
Month Day Year
May 14 19 67 | | | | | |
| 5 SEX
Female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
4-16-89 | | 9. AGE (In years last birthday)
78 yrs | | IF UNDER 1 YEAR
Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME
Guy Gamberdell | | | | | | 14. MOTHER'S MAIDEN NAME
Laurina (Maurig) Maurio | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO
220449470 | | 17. INFORMANT
Address
Mr. Lawrence J. Panico, 1806 Willann Rd. #6 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
(b) Chronic Pulmonary Disease
DUE TO
(c) Congestive Heart Failure 'secondary to A.S.C.V.D. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from May 14 , 19 67 to May 14 , 19 67 that (I) (we) last saw the deceased alive on May 14 , 19 67 , and that death occurred at 6.30 PM from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Ramon P. Lopez | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
5-14-67 | | | |
| 22c. PHYSICIAN'S NAME (Type) Ramon P. Lopez | | | | | | 22d. ADDRESS
7620 York Rd. Baltimore, Md. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-17-67. | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial Cem. | | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | | | 25a. REC'D BY REGISTRAR
MAY 15 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~insert~~ ^{insert} approved carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06376

CERTIFICATE OF DEATH

06366

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY IN 1b
2 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle BENJAMIN Last PARKER | | 4. DATE OF DEATH
Month MAY Day 31 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/28/19 |
| 9. AGE (In years last birthday)
47 yrs | | 10. IF UNDER 1 YEAR
Months 4 Days 2 Hours 1 Min 0 | 11. IF UNDER 24 HRS
Months 0 Days 0 Hours 0 Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY
Fisher Auto Parts | |
| 11. BIRTHPLACE (County & State or foreign country)
Benson, North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Lester Parker | | 14. MOTHER'S MAIDEN NAME
Eleanora Beasley | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW II | | 16. SOCIAL SECURITY NO
217-03-85-37 | |
| 17. INFORMANT
Clinical Records, VAH, Fort Howard, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
4-7 MONTHS | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 29 , 19 67 , to May 31 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 31 , 19 67 , and that death occurred at 4:00AM from causes and on the date stated above | | | |
| 22a. SIGNATURE
<i>George C. McElpatrick M.D.</i> | | 22b. DATE SIGNED
5/31/67 | |
| 22c. PHYSICIAN'S NAME (Type)
GEORGE C. MC ELPATRICK, M. D. | | 22d. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
6/3/1967 | 23c. NAME OF CEMETERY OR CREMATORY
Louder Park Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
Wm. J. Tickner & Sons | | 25a. REC'D BY REGISTRAR
North & Pennsylvania Baltimore, Maryland | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | DATE JUN 1 1967 | |

enriched

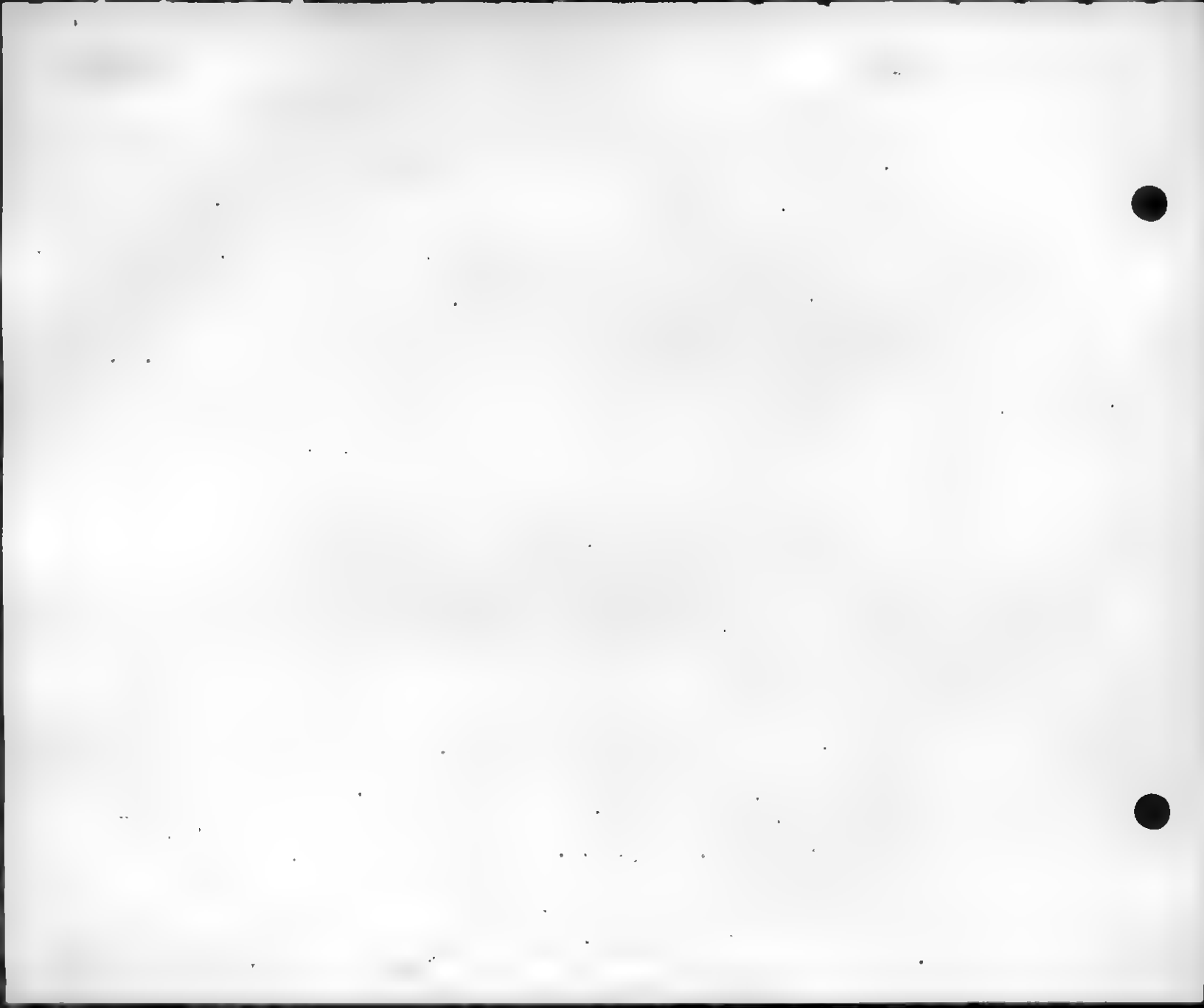
2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|--|---|---|--|----------------------------------|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 06377 CERTIFICATE OF DEATH 05267 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>
c. LENGTH OF STAY IN 1b <u>4yr5mth18dys</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY _____
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>
d. STREET ADDRESS <u>419 North Pulaski Street</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Mary</u> Middle <u>Bessie</u> Last <u>Pearce</u> | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>2</u> Year <u>1967</u> | | | | | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Nov. 25, 1891</u> | | 9. AGE (In years last birthday) <u>75</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | | |
| 13. FATHER'S NAME <u>Samuel Pearce</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Phoebe Christina Boyd</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NO ONE</u> | | 17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>
DUE TO (b) <u>Bronchopneumonia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <u>Generalized arteriosclerosis</u> | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21. I certify that <u>he</u> (this hospital) attended the deceased from <u>Nov. 14, 1962</u> to <u>May 2, 1967</u> , that <u>he</u> (we) last saw the deceased alive on <u>May 2, 1967</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Anthony J. Young, M.D.</u> | | | | a. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <u>5-2-67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Anthony J. Young, M.D.</u> | | | | 22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>
<u>Baltimore, Maryland 21228</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>5-5-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u> | | 23d. LOCATION (City, town or county) <u>BALTO. County Md.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Geo. L. Schwab FUNERAL HOME</u>
<u>Francis H. Miller 2101 Frederick Ave.</u> | | | | 25a. REC'D BY REGISTRAR <u>DATE MAY 4 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>McLearle Judge</u> | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

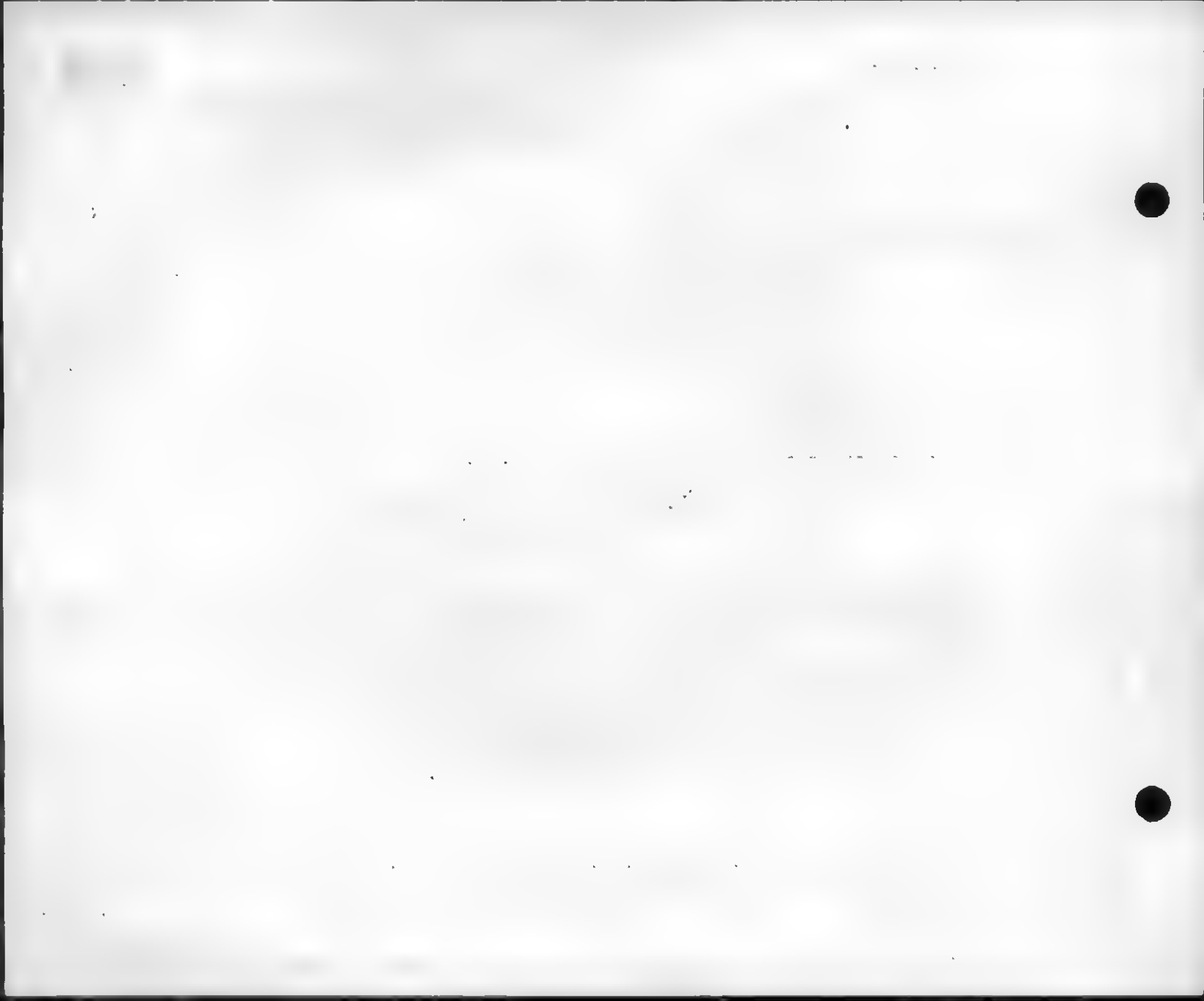
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06378

06368

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Texas | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Texas | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
138 Church Lane | | d. STREET ADDRESS
138 Church Lane | |
| 3. NAME OF DECEASED (Type or print)
First DORA Middle ELIZABETH Last PERRY | | 4. DATE OF DEATH
Month May Day 2 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 21, 1880 |
| 9. AGE (In years last birthday)
86 yrs | | 10. IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Joshua Green | | 14. MOTHER'S MAIDEN NAME
Mary Elizabeth Martin | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
18-54-2912J1 | |
| 17. INFORMANT
Mr. C. Lester Perry, Same as # 2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thromboses MULTIPLE
332X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Cerebral Arteriosclerosis
(c) | | INTERVAL BETWEEN ONSET AND DEATH
10 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from Aug 24, 1966 to 4/27/1967 , that (1) (we) last saw the deceased alive on 4/27/1967 , and that death occurred at 11:00 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Donald O. Wood | | 22b. DATE SIGNED
5/3/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Donald O. Wood, M. D. | | 22d. ADDRESS
York Rd. and Greenmeadow, Timonium, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
May 5, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Jessop Cemetery | 23d. LOCATION (City or town) (County) (State)
Sparks, Baltimore Co., Md. |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204 | | 25a. REC'D BY REGISTRAR
MAY 5 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

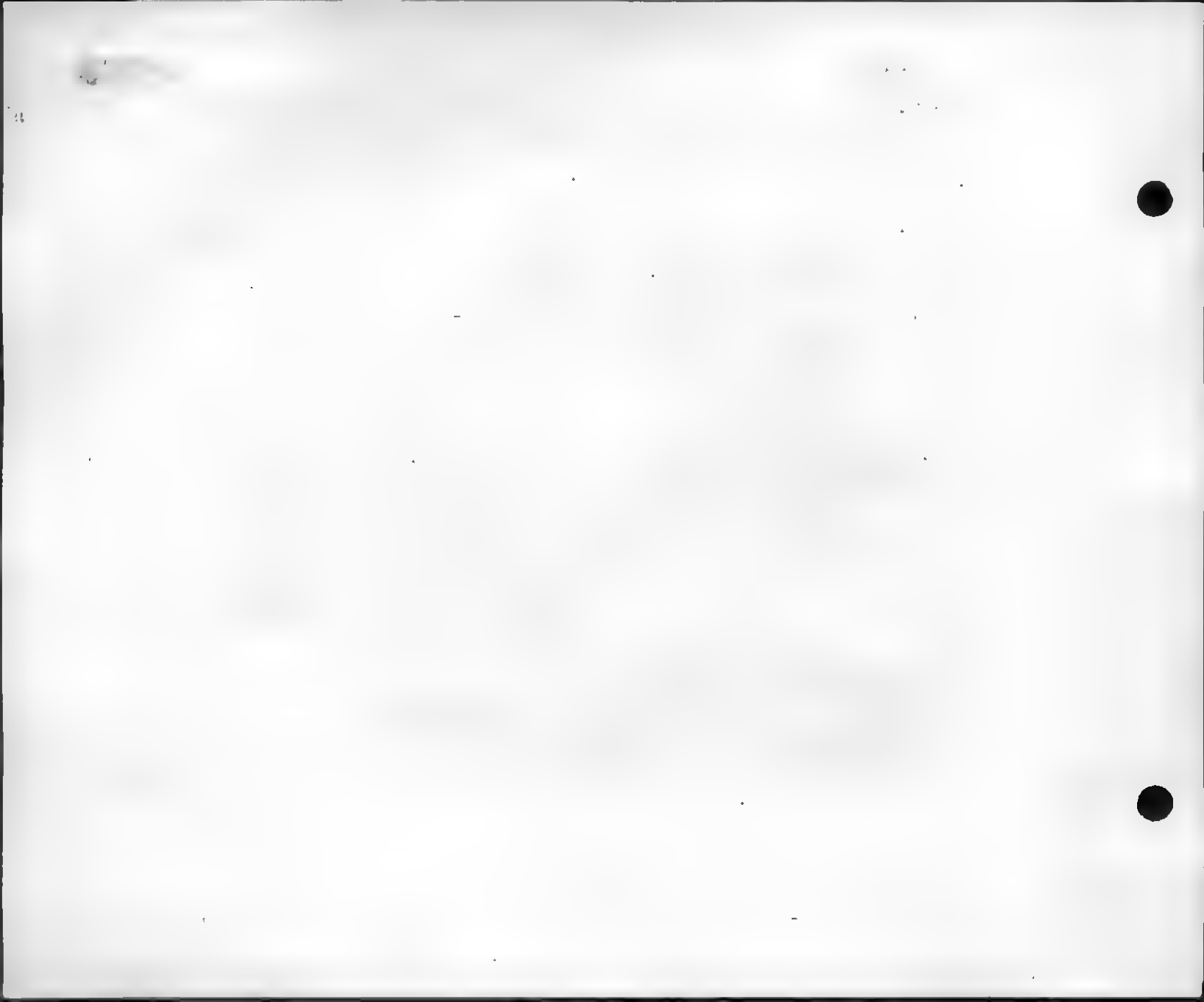
06379

06369

| | | | | | | | | | |
|--|--|-----------------------------------|---|--|--|---|--|--|--|
| 1 PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | c LENGTH OF STAY IN 1b
7 yrs. | | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
3604 Tulsa Road | | | | | | d STREET ADDRESS
3604 Tulsa Road | | e IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print)
Margaret A. Pfeiffer | | | | 4 DATE OF DEATH
May 29 1967 | | | | | |
| 5 SEX
Female | | 6. COLOR OR RACE
White | | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH
1-27-1875 | | 9 AGE (in years last birthday)
92 yrs | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At Home | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (County & State, or foreign country)
Baltimore County | | | | 12 CITIZEN OF WHAT COUNTRY?
USA | |
| 13 FATHER'S NAME
John Murk | | | | 14 MOTHER'S MAIDEN NAME
Mary Blum | | | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | | | 16 SOCIAL SECURITY NO
None | | 17 INFORMANT Address
Carroll L. Pfeiffer - 645 Coventry Rd. #4 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease
DUE TO (b) Cerebral Thrombosis
DUE TO (c) Diverterculitis of Sigmoid Colon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 yrs
4 days
2 yrs | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)
Generalized arterio Sclerosis | | | | | | | | 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 5 - 1950 , to May 29, 1967 , that (I) was last saw the deceased alive on May 27 1967 , and that death occurred at 11:54 P.M. from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Earl L. Chambers | | | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | 22b DATE SIGNED
5/31/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Earl L. Chambers | | | | 22d ADDRESS
4108 Liberty Hts Balto. Md | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b DATE THEREOF
6-1-67 | | 23c NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | | 23d LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | |
| 24 FUNERAL DIRECTOR
Ellsworth Armacost - 4600 Liberty Hghts. | | | | | | 25a. REC'D BY REGISTRAR
DATE JUN 1 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06380

CERTIFICATE OF DEATH

06370

| | | | |
|---|---|--|---|
| 1 PLACE OF DEATH
a. COUNTY <u>Baltimore Co.</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | c. LENGTH OF STAY IN 1b
<u>Yrs</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Aged Woman's & Men's Home</u> | | d. STREET ADDRESS
<u>504 Delaware Ave.</u> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Annette</u> Middle <u>Phibbs</u> Last <u>Phibbs</u> | | 4. DATE OF DEATH
Month <u>May</u> Day <u>28</u> Year <u>1967</u> | |
| 5. SEX
<u>F.</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 18-1876</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (in years last birthday) yrs <u>90</u> MONTHS <u>1</u> DAYS <u>19</u> HOURS <u>67</u> |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Phibbs, James</u> | | 14. MOTHER'S MAIDEN NAME
<u>Higle, Josephine</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>215 48 7946</u> | |
| 17. INFORMANT
<u>M. Elta McEish</u> | | Address
<u>615 Chestnut Ave</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac insufficiency</u>
DUE TO (b) <u>Arteriosclerotic heart disease</u>
DUE TO (c) <u>Generalized chronic arteriosclerosis, systemic.</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Terminal</u>
<u>years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 3, 1960</u> , to <u>May 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 28, 1967</u> , and that death occurred at <u>2 A.M.</u> from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Edwin B. Jarrett</u> | | 22b. DATE SIGNED
<u>5/28/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Edwin B. Jarrett, M.D.</u> | | 22d. ADDRESS
<u>11 East Chase St., City-2.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>May 31, 67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Govans Presbyterian</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Towson, Md. Balto.</u> |
| 24. FUNERAL DIRECTOR
<u>Wm. Cook-Brooks Towson, Towson, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 31 1967</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD 9526
 MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06381

CERTIFICATE OF DEATH

07844

| | | | |
|--|------------------------------|---|------------------------------------|
| 1 PLACE OF DEATH
a. COUNTY
Baltimore County MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland b. COUNTY Howard | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mount Wilson | | c. LENGTH OF STAY IN 1b
5 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Mount Wilson State Hospital | | e. STREET ADDRESS
HENRYTON Rd. | |
| 3 NAME OF DECEASED (Type or print)
First HARRY Middle CORNELIUS Last PIERCE | | 4. DATE OF DEATH
Month MAY Day 18 Year 1967 | |
| 5 SEX
M. | 6 COLOR OR RACE
N. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-16-06 |
| 9. AGE (In years lost birthday)
61 yrs | | 10. IF UNDER 1 YEAR
Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY
Id | |
| 11. BIRTHPLACE (County & State, or foreign country)
Id | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN PIERCE | | 14. MOTHER'S MAIDEN NAME
ANNIE BUTLER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO
231-10-5326 | |
| 17. INFORMANT
Records, Mount Wilson State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO
(c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above | | | |
| 22a. SIGNATURE
W. Newcomer | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Wm. Newcomer, M.D., Superintendent Mount Wilson, Maryland | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
May 24, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St. Anthony's | | 23d. LOCATION (City or town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Frank D. Newell, Pikesville, Md. | | 25a. REC'D BY REGISTRAR
JUN 7 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Jua | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

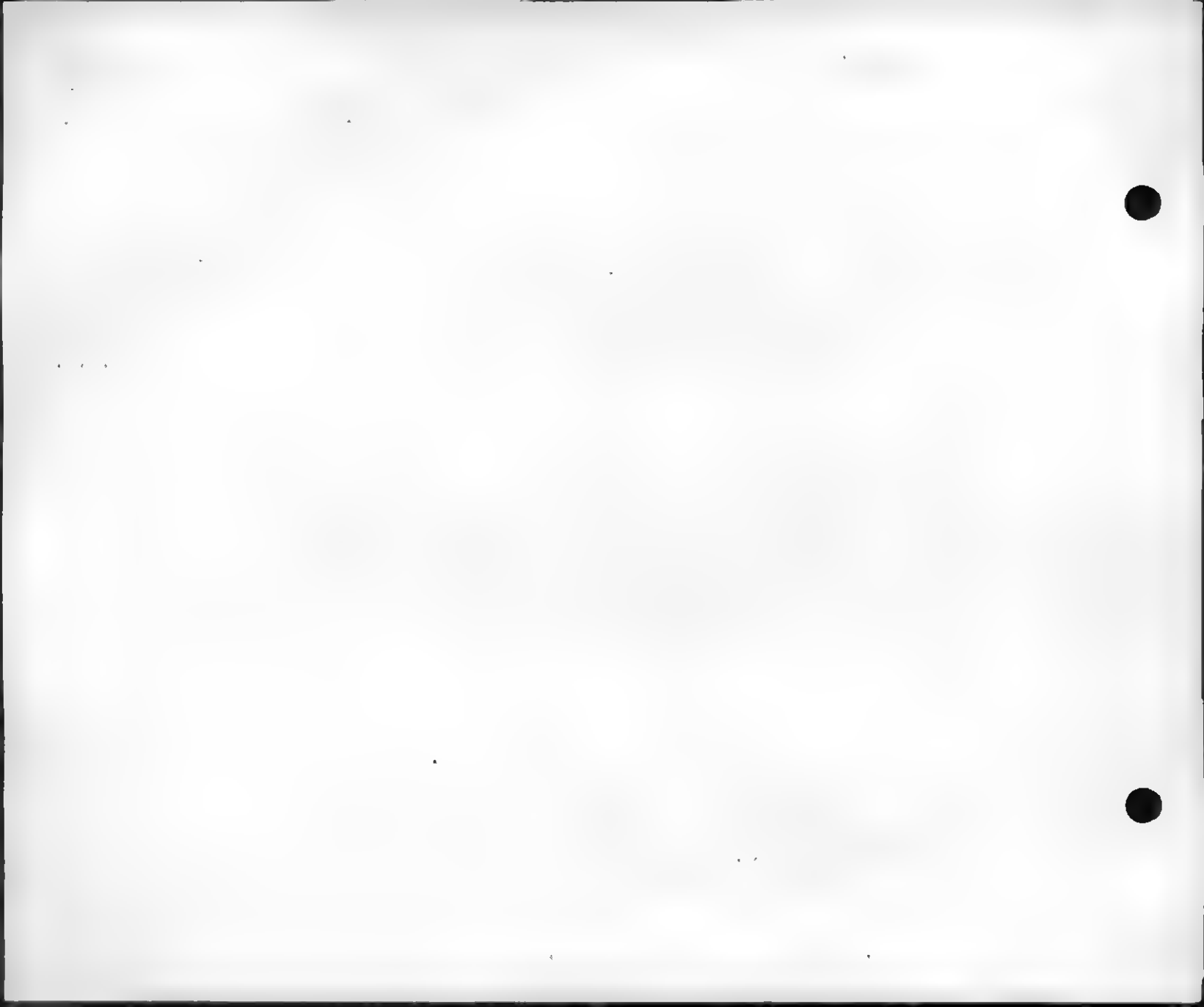
06382

CERTIFICATE OF DEATH

1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|---|
| 1 PLACE OF DEATH
a. COUNTY BALTIMORE
MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE MD. b COUNTY BALTO. | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CATONSVILLE | | c LENGTH OF STAY IN 1b
CATONSVILLE | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
9 OVERBROOK ROAD | | d STREET ADDRESS
9 OVERBROOK ROAD
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print)
First MINNIE Middle C. Last POOLE | | 4 DATE OF DEATH
Month MAY Day 31 Year 1967 | |
| 5 SEX
FEMALE | 6 COLOR OR RACE
WHITE | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
1-16-1883 |
| 9 AGE (in years last birthday)
84 yrs | | 10 UNDER 1 YEAR
Months Days Hours Min. | 11 UNDER 24 HRS |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (County & State, or foreign country)
Maryland |
| 12 CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13 FATHER'S NAME
Wm. Frankle | |
| 14 MOTHER'S MAIDEN NAME
Margaret Bauer | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | |
| 16 SOCIAL SECURITY NO
220-44-5540 | | 17 INFORMANT Address
Mrs. Thelma Johnson, 345 Martingale Ave. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion, Acute
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Arteriosclerotic Heart Disease
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
Sudden
6 mos. | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f (City or town) (County) (State) |
| 21. I certify that (I) (the hospital) attended the deceased from Aug. , 19 63 , to May 1967 , 19 67 , that (I) (we) last saw the deceased alive on May 3 , 19 67 , and that death occurred at 11:45 AM from causes and on the date stated above | | | |
| 22a. SIGNATURE
Leo J. Gaver M.D. | | 22b. DATE SIGNED
5/31/67 | 22c. PHYSICIAN'S NAME (Type)
LEO J. GAVER |
| 22d ADDRESS
1 MALLOW HILL ROAD | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b DATE THEREOF
6-3-1967 | 23c NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | 23d LOCATION (City or Town) (County) (State)
Baltimore, Maryland |
| 24 FUNERAL DIRECTOR
HOWARD H. HUBBARD 4107 WILKENS AVE. 21229 | | 25a REC'D BY REG-STRAR
JUN 2 1967 | 25b REGISTRAR'S SIGNATURE
Johnas Judge |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

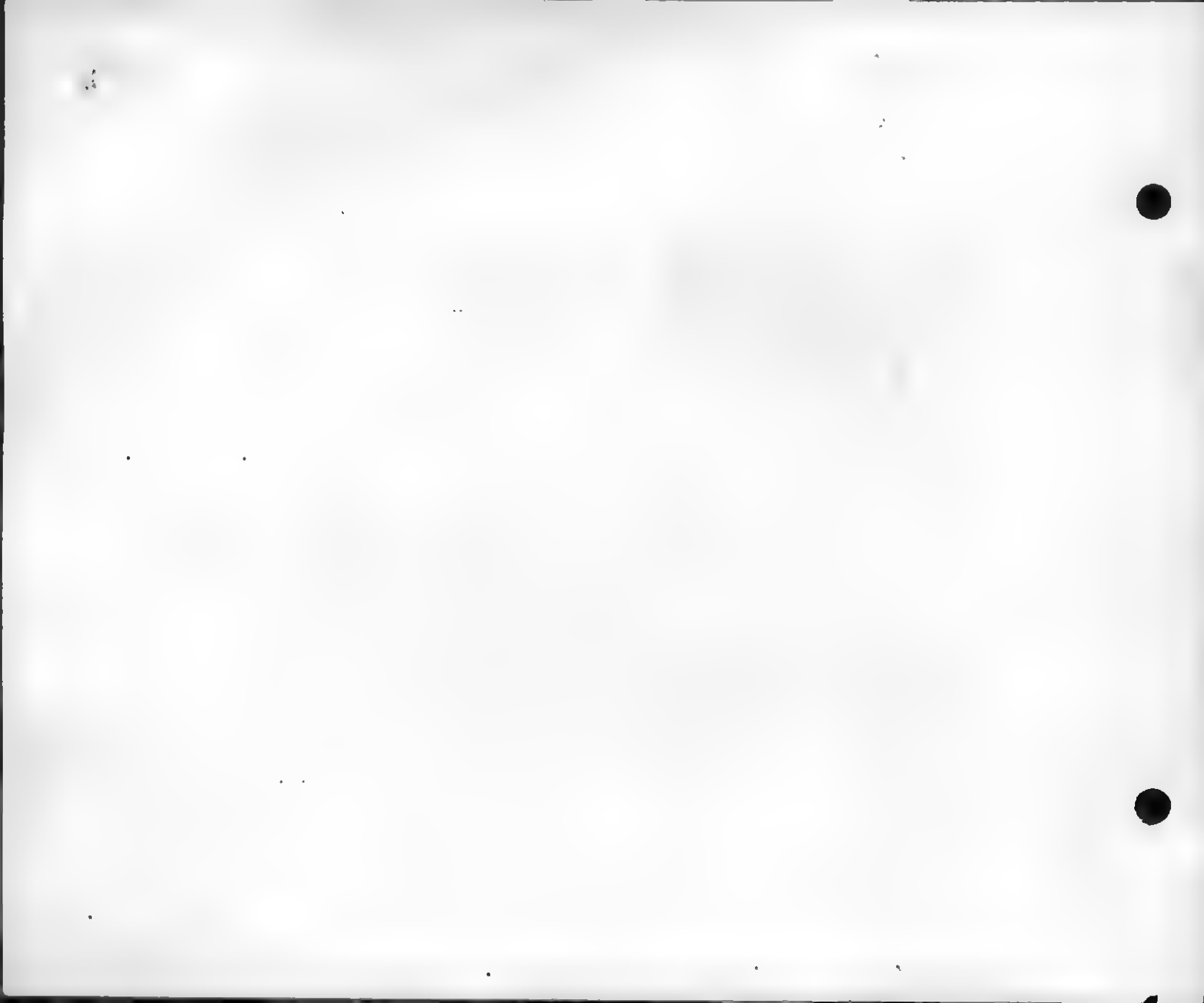
06383

Item #8 Film #330 6/2/67 PC

CERTIFICATE OF DEATH

06372

| | | | | | | | |
|--|--|---|--|--|---|---|---|
| 1 PLACE OF DEATH
a COUNTY Baltimore
MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland
b. COUNTY | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | c LENGTH OF STAY in 1b | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address)
St. Josephs Hospital | | | | d. STREET ADDRESS
321 East 30th Street | | e IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print)
First John Middle Thomas Last POTEET | | | | 4. DATE OF DEATH
Month May Day 28 Year 19 67 | | | |
| 5 SEX
male | | 6 COLOR OR RACE
white | | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH
8-28-93 91 | |
| 9 AGE (in years last birthday)
75 yrs | | 10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)
Insurance retired | | 10b KIND OF BUSINESS OR INDUSTRY
Self | | 11. BIRTHPLACE (County & State, or foreign country)
Harford County, Md. | |
| 12 CITIZEN OF WHAT COUNTRY?
USA | | | | 13. FATHER'S NAME
Sheffield Poteet | | | |
| 14. MOTHER'S MAIDEN NAME
Unknown | | | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | |
| 16 SOCIAL SECURITY NO
218-18-1210A | | | | 17. INFORMANT
Address Mrs. Mary Poteet 321 E. 30th St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia involving the right and left lungs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure secondary to arterio-sclerotic and rheumatic heart disease.
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | |
| 20c TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d INJURY OCCURRED
White <input type="checkbox"/> Not White <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (A) (this hospital) attended the deceased from May 19 , 19 67 , to May 28 19 67 , that (A) (we) last saw the deceased alive on May 28 19 67 , and that death occurred at 8:20 P.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Lawrence F. Misanik | | | | M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
May 29, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Lawrence F. Misanik, M.D. | | | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
6/1/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Goodwill Church Cemetery | | 23d. LOCATION (City or town) (County) (State)
Harford County, Md. | |
| 24. FUNERAL DIRECTOR
John A. Moran, Inc. 3000 E. Baltimore St. | | | | 25a. REC'D BY REGISTRAR
MAY 31 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

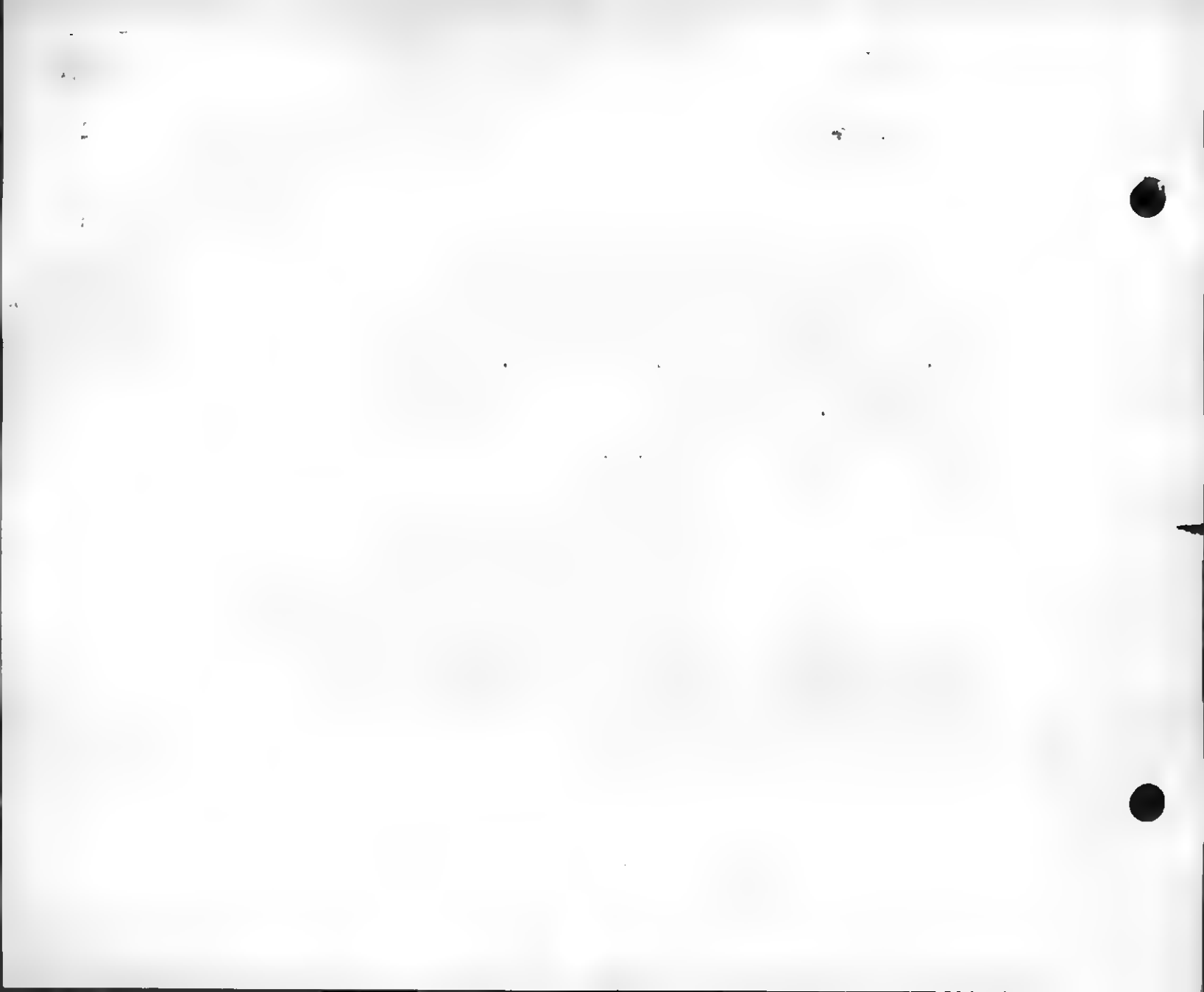
06384

CERTIFICATE OF DEATH

16273

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---|--|--|
| 1 PLACE OF DEATH
a. COUNTY
Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN 1b
Baltimore 21234 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | d. STREET ADDRESS
34 Dowling Circle | |
| 3 NAME OF DECEASED
(Type or print)
First Middle Last
Jack Warren POWELL | | 4 DATE OF DEATH
Month Day Year
May 31, 19 67 | |
| 5 SEX
Male | 6 COLOR OR RACE
White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
12-12-17 |
| 9 AGE (In years lost birthday)
49 yrs | | F UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)
Mr. Artisan Flooring | | 10b. KIND OF BUSINESS OR INDUSTRY
Mr. retail Inst. | |
| 11 BIRTHPLACE (County & State, or foreign country)
Maryland | | 12 CITIZEN OF WHAT COUNTRY?
USA | |
| 13 FATHER'S NAME
Charles E. Powell | | 14 MOTHER'S MAIDEN NAME
Blanche Aban | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
WW2 | | 16. SOCIAL SECURITY NO
215-18-8863 | |
| 17. INFORMANT
Family records | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Pulmonary edema
DUE TO congestive heart failure
(b) Inoperable carcinoma of the lung
DUE TO Arteriosclerosis.
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year
Hour o m. p.m. 19 | 20d INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 6, 19 67 , to May 31, 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 31, 19 67 , and that death occurred at 7:30AM , from causes and on the date stated above. | | | |
| 22a SIGNATURE
Roberto Ferrer | | 22b DATE SIGNED
May 31, 1967 | |
| 22c PHYSICIAN'S NAME (Type) Roberto Ferrer, M.D. | | 22d ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | 23b DATE THEREOF | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION (City or Town) (County) (State) |
| Burial | 6/3/67 | Loudon Park Cemetery | Balt. |
| 24 FUNERAL DIRECTOR
ADDRESS
John Burns Sons Towson, Md. 21204 | | 25a REC'D BY REGISTRAR
DATE JUN 5 1967 | |
| | | 25b REGISTRAR'S SIGNATURE
Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06385

06374

| | | | |
|--|---|---|--|
| 1 PLACE OF DEATH
a. COUNTY <u>BAITIMORE</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u> | | d. STREET ADDRESS <u>6123 FAIRIS ROAD</u> | |
| 3 NAME OF DECEASED (Type or print)
First <u>FRANCES</u> Middle <u>VERNON</u> Last <u>PRESTON</u> | | 4. DATE OF DEATH
Month <u>MAY</u> Day <u>15</u> Year <u>1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>CAU</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10/7/84</u> |
| 9. AGE (in years last birthday) <u>82</u> yrs | | 10. IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>RETIRED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11 BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE CO., MD.</u> | | 12 CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13 FATHER'S NAME <u>Charles Preston</u> | | 14 MOTHER'S MAIDEN NAME <u>Hildt</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNK.</u> | | 16. SOCIAL SECURITY NO <u>21705-9822</u> | |
| 17. INFORMANT <u>Patients chart</u> | | Address <u>—</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>respiratory arrest</u>
DUE TO <u>cerebrovascular accident</u>
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost. <u>ASCVD</u>
(b) <u>—</u>
(c) <u>—</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 mins</u>
<u>3 days</u>
<u>undit.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u>—</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5-13</u> , 19 <u>67</u> to <u>5-15</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>5-15</u> , 19 <u>67</u> , and that death occurred at <u>8:20</u> M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>V.R. Batoyon</u> | | 22b. DATE SIGNED <u>5-15-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>V. R. BATOYON</u> | | 22d. ADDRESS <u>—</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>5/18/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL</u> | 23d. LOCATION (City or Town) (County) (State) <u>TOWSON BALTO. MD.</u> |
| 24. FUNERAL DIRECTOR <u>John Burns Sons</u> | | 25a. REC'D BY REGISTRAR <u>May 22 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>John Burns Sons</u> | | 25c. REGISTRAR'S SIGNATURE <u>John Burns Sons</u> | |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

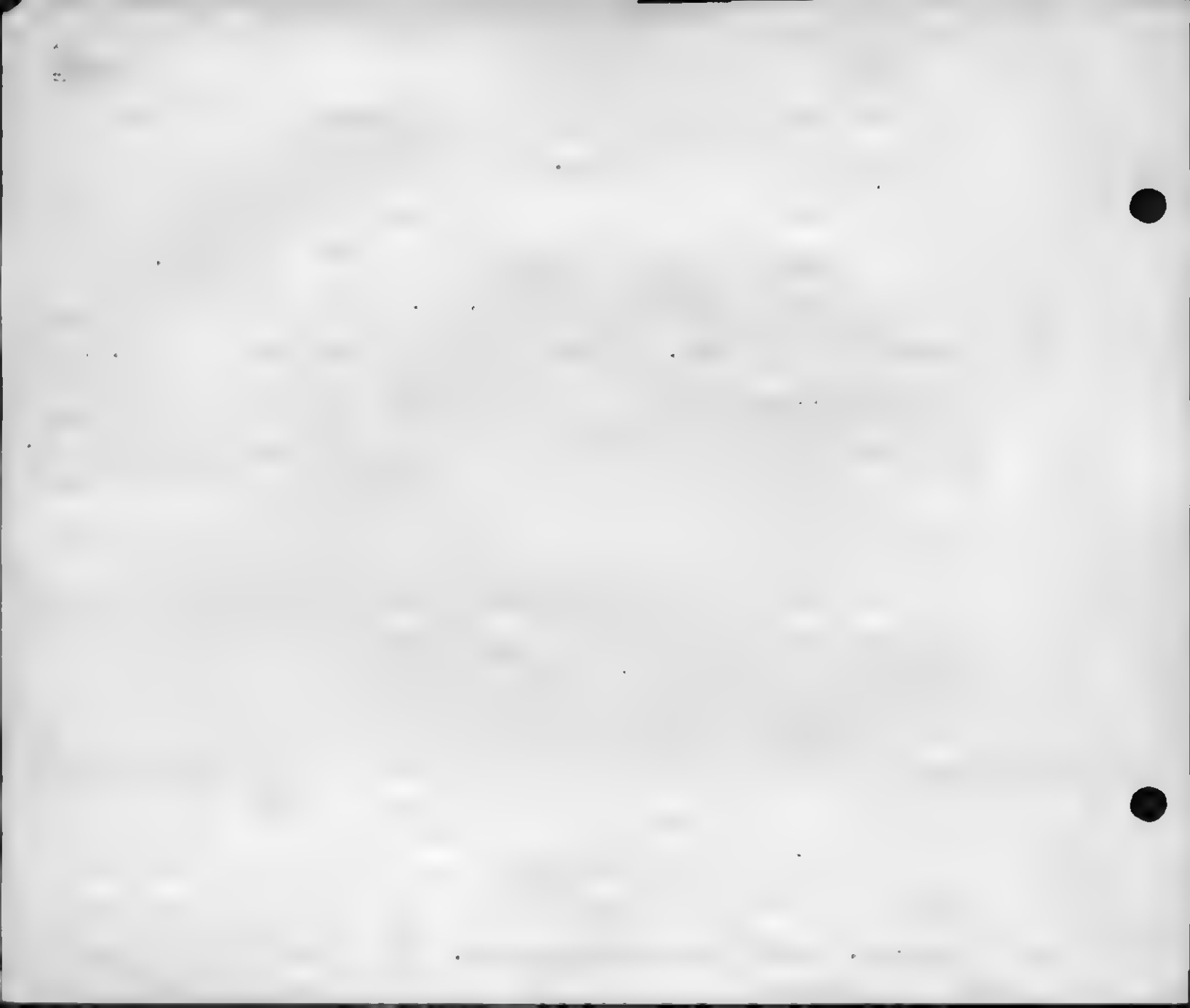
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06375

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Phoenix
c. LENGTH OF STAY IN 1b 98 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cooper Road | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Phoenix
d. STREET ADDRESS Cooper Road | | | |
| 3. NAME OF DECEASED
(Type or print) Charles Marion Price | | | | 4. DATE OF DEATH
Month May Day 20 Year 1967 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 18, 1869 | |
| 9. AGE (In years last birthday) 98 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Gen. farming | | 11. BIRTHPLACE (County & State, or foreign country) Phoenix, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME Robert Oliver Price | | | |
| 14. MOTHER'S MAIDEN NAME Elenor Royston | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | |
| 16. SOCIAL SECURITY NO. 220-54-6542 | | | | 17. INFORMANT Mrs. Elenor P. Shepperd | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-vascular accident
12211 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) none | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 1964 to May 20, 1967 , that (I) was saw the deceased alive on May 17, 1967 , and that death occurred at 6 A.M. from the causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE James F. White Jr. | | | | 22b. DATE SIGNED 5/20/67 | | 22c. PHYSICIAN'S NAME (Type) James F. White Jr. M.D. | |
| 22d. ADDRESS Jarrettsville, Md. 21044 | | | | 22e. REC'D BY REGISTRAR MAY 23 1967 | | | |
| 22f. REGISTRAR'S SIGNATURE Charles E. Kurtz | | | | 22g. NAME OF CEMETERY OR CREMATORY Clynmalira | | | |
| 22h. LOCATION (City, town or county) (State) Monkton, Maryland | | | | 22i. DATE | | | |
| 22j. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22k. DATE THEREOF 5/23/1967 | | | |
| 22l. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kurtz | | | | 22m. ADDRESS Jarrettsville, Md. 21084 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

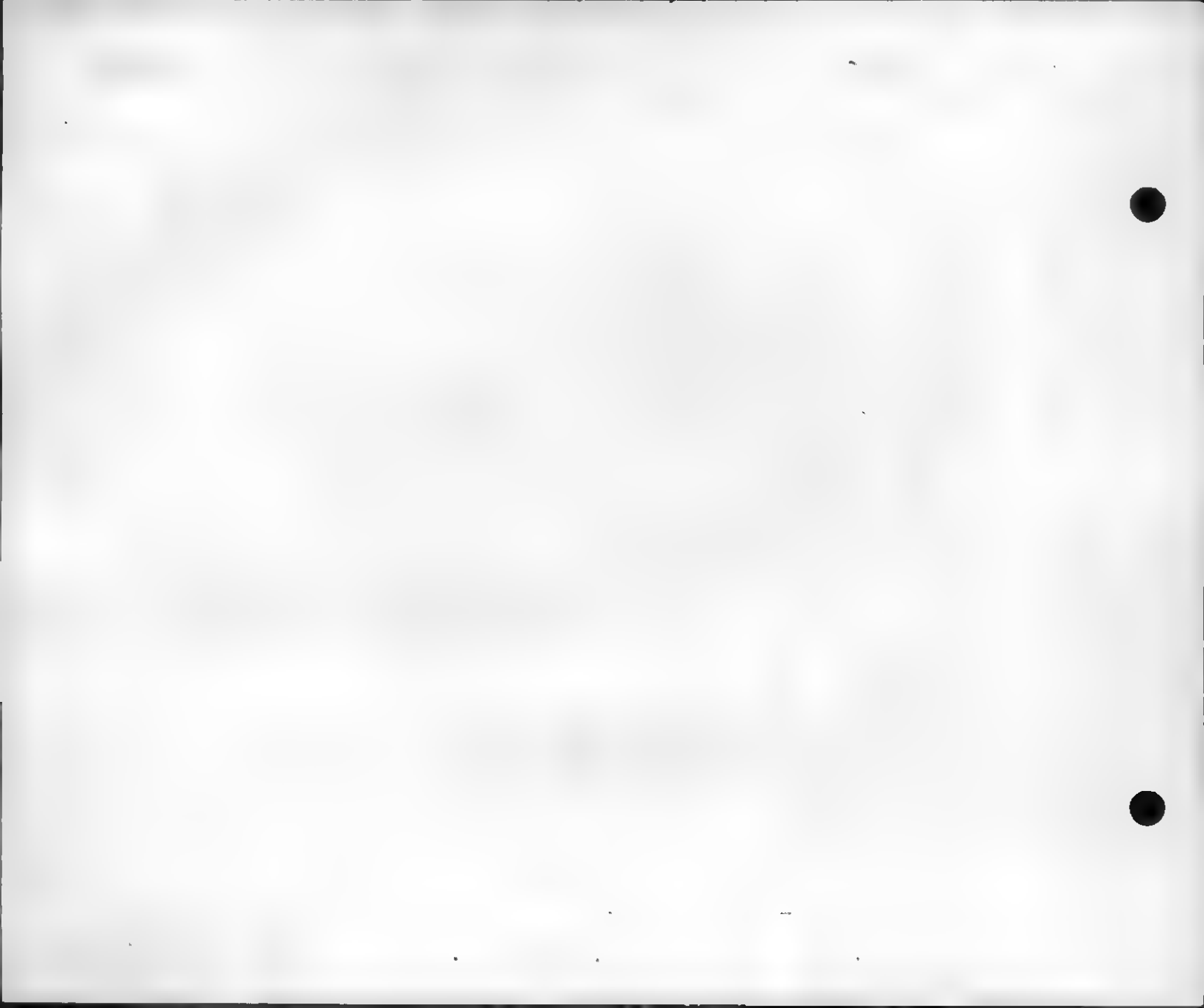
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06388

CERTIFICATE OF DEATH

J6377

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Dundalk Md.</u> | | c. LENGTH OF STAY IN TB
<u>50 yrs</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Dundalk Md.</u> | | d. STREET ADDRESS
<u>302 SOLLERS PT. RD.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>403 New Pittsburgh Ave.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Henry</u> Middle <u>Osborne</u> Last <u>Pryor</u> | | 4. DATE OF DEATH
Month <u>May</u> Day <u>24</u> Year <u>1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>Col</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept. 6, 1892</u> |
| 9. AGE (In years last birthday)
<u>74</u> yrs | | 10. IF UNDER 1 YEAR
Months <u>8</u> Days <u>18</u> Hours <u>-</u> Min <u>-</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)
<u>Crane Operator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Ship Yard</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Keyville, Va.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Samuel Pryor</u> | | 14. MOTHER'S MAIDEN NAME
<u>Virginia Green</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO
<u>213-07411</u> | |
| 17. INFORMANT
<u>Horace Pryor</u> | | Address
<u>301 Pine St.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u>
DUE TO
(b) <u>Uremia</u>
DUE TO
(c) <u>Arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>3</u>
<u>5 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 1950 to <u>May 24</u> , 1967, that (I) (we) last saw the deceased alive on <u>May 24</u> , 1967, and that death occurred at <u>3 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>William C. Wade</u> | | 22b. DATE SIGNED
<u>May 24, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>William C. Wade, M.D.</u> | | 22d. ADDRESS
<u>140 Oak Avenue Dundalk Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>5-27-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Calvary Cemetery</u> | 23d. LOCATION (City or town) (County) (State)
<u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>Charles R. Law</u> | | 25a. REC'D BY REGISTRAR
<u>24 1967</u> | |
| ADDRESS
<u>802 Madison Ave., Balto., Md.</u> | | 25b. REGISTRAR'S SIGNATURE
<u>William C. Wade</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06387

CERTIFICATE OF DEATH

06376

| | | | |
|---|--|---|--|
| 1 PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Shady Nook Nursing Home | | d. STREET ADDRESS
200 Mallow Hill Rd. | |
| 3 NAME OF DECEASED (Type or print)
First Mary Middle E. Brown Last Raley | | 4 DATE OF DEATH
Month May Day 23 Year 1967 | |
| 5 SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
3/6/92 |
| 9 AGE (In years last birthday)
75 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Registered Nurse | |
| 11. BIRTHPLACE (County & State, or foreign country)
Freeland, Md. | | 12 CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Brown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO
220-24-1273 | |
| 17 INFORMANT
Edward Kaplitz | | Address
4603 Wilkens Ave. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arteriosclerotic Cardiovascular Disease
DUE TO Heart
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) severe peripheral arteriosclerosis
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Oct. 12, 1962 to May 23, 1967 , that (I) was saw the deceased alive on May 22, 1967 , and that death occurred at 5:00 AM , from causes and on the date stated above. | | | |
| 22a SIGNATURE
Dr. Harry Knipp | | 22b DATE SIGNED
5-23-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Harry Knipp | | 22d. ADDRESS
4116 Edmondson Ave. 21229 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b DATE THEREOF
5/25/67 | 23c NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery Baltimore, Maryland | 23d LOCAT ON (City or Town) (County) (State) |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard | | 25a. REC'D BY REGISTRAR
MAY 25 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

063883

Clinton Lang Reckord

2. DATE AND HOUR OF DEATH

May 9, 1967 052782 P.

1. NAME OF DECEASED
(Type or Print)

(Reckord)

3. PLACE OF DEATH IN BALTIMORE-MARYLAND

Baltimore County

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

A. STATE Maryland B. COUNTY Harford

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Bel Air

D. STREET ADDRESS (If rural, give location)

163 North Williams Street

5. SEX

male

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

Oct. 18, 1886

9. AGE (In years
last birthday)

80

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Auditor

10B. KIND OF BUSINESS OR INDUSTRY

Race Track

11. BIRTHPLACE (State or foreign country)

Harford Co., Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Reckord

14. MOTHER'S MAIDEN NAME

Lydia A. Zimmerman

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) If yes, give war or dates of service

NO

16. SOCIAL
SECURITY NO.

432-01-0241

17. INFORMANT (Write)

Mrs. Isabel O.C. Reckord 163 N. Williams St.
Bel Air, Maryland 21014

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) Coronary Insufficiency

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

Acute

(B) Arterio-sclerotic heart disease 3 yrs.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT

22. I certify that (I) (this hospital) attended the deceased from July 19 64 to May 9, 19 67.

that (I) (we) last saw the deceased alive on May 9 19 67 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

C. Edward Leach

M.D.

Attending
Phys.

☒

Med.
Director

☐

Staff
Phys.

☐

23B. DATE SIGNED

5-10-67

23C. PHYSICIAN'S
NAME (Type)

C. Edward Leach

M.D.

23D. ADDRESS

14 E. Eager St.

Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

May 12, 1967

24C. NAME of CEMETERY or CREMATORY

Mountain Christian Church Cem.

24D. LOCATION

Joppa, Harford Co., Maryland

(City, town, or county)

(State)

VR A15 (4)
25M 1/67

25A. DATE RECD. BY HEALTH OFFICER

MAY 16 1967

Charles Judge

25C. FUNERAL DIRECTOR

Joseph William Foster 163 N. Williams St.
Bel Air, Maryland 21014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.



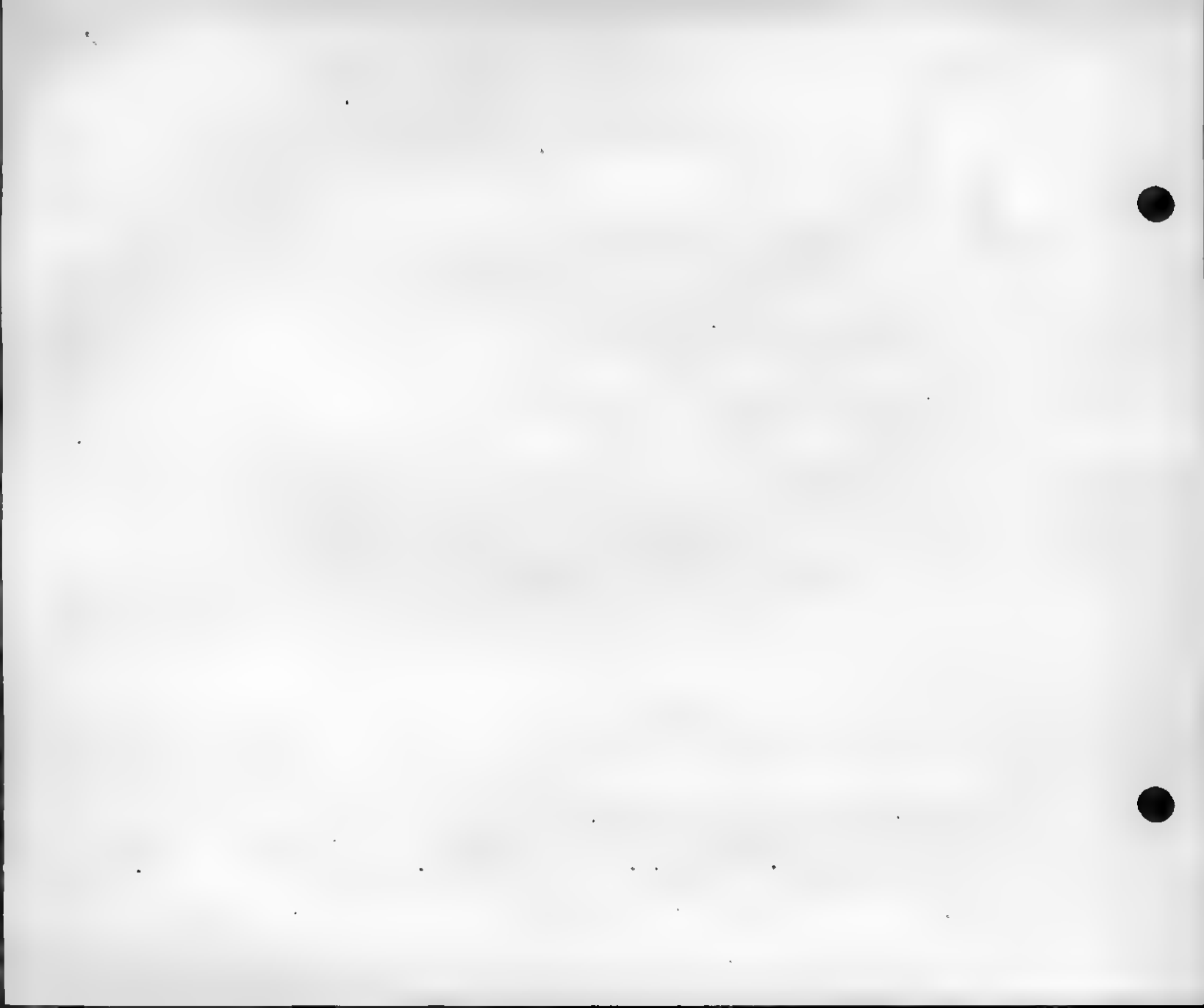
CERTIFICATE OF DEATH

Reg. Dist. No.

15778

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | c. LENGTH OF STAY IN 1b <u>20 years</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Notre Dame Motherhouse</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Egwing Sr. Mary Reich</u> | | 4. DATE OF DEATH <u>May 11 1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 26, 1882</u> |
| 9. AGE (In years last birthday) <u>84</u> yrs. | | 10. IF UNDER 1 YEAR | 10. IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Religious</u> | 11. BIRTHPLACE (State or foreign country) <u>Prussia</u> |
| 13. FATHER'S NAME <u>Reich, Anthony</u> | | 14. MOTHER'S MAIDEN NAME <u>Blum, Anna</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>218-34-3692</u> | |
| 17. INFORMANT <u>JL Sr. M. Ernest</u> | | Address <u>6401 N. Charles St.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
DUE TO <u>Primary Sick Not Determined</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Assault</u>
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of stem 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>11-9</u> , 19 <u>66</u> , to <u>5-11</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>5-10</u> , 19 <u>67</u> , and that death occurred at <u>11:55 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Robert J. Johnson</u> | | ADDRESS (Street, city or town, state) <u>204 E. Jones Road, Towson, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Robert J. Johnson, M.D.</u> | | DATE SIGNED <u>MAY 22 1967</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>May 15, 1967</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Sisters Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Glen Arm, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond J. Currah</u> | | 24a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| ADDRESS <u>817 Scarlett Dr. Towson, Md.</u> | | 24b. REGISTRAR'S SIGNATURE | |

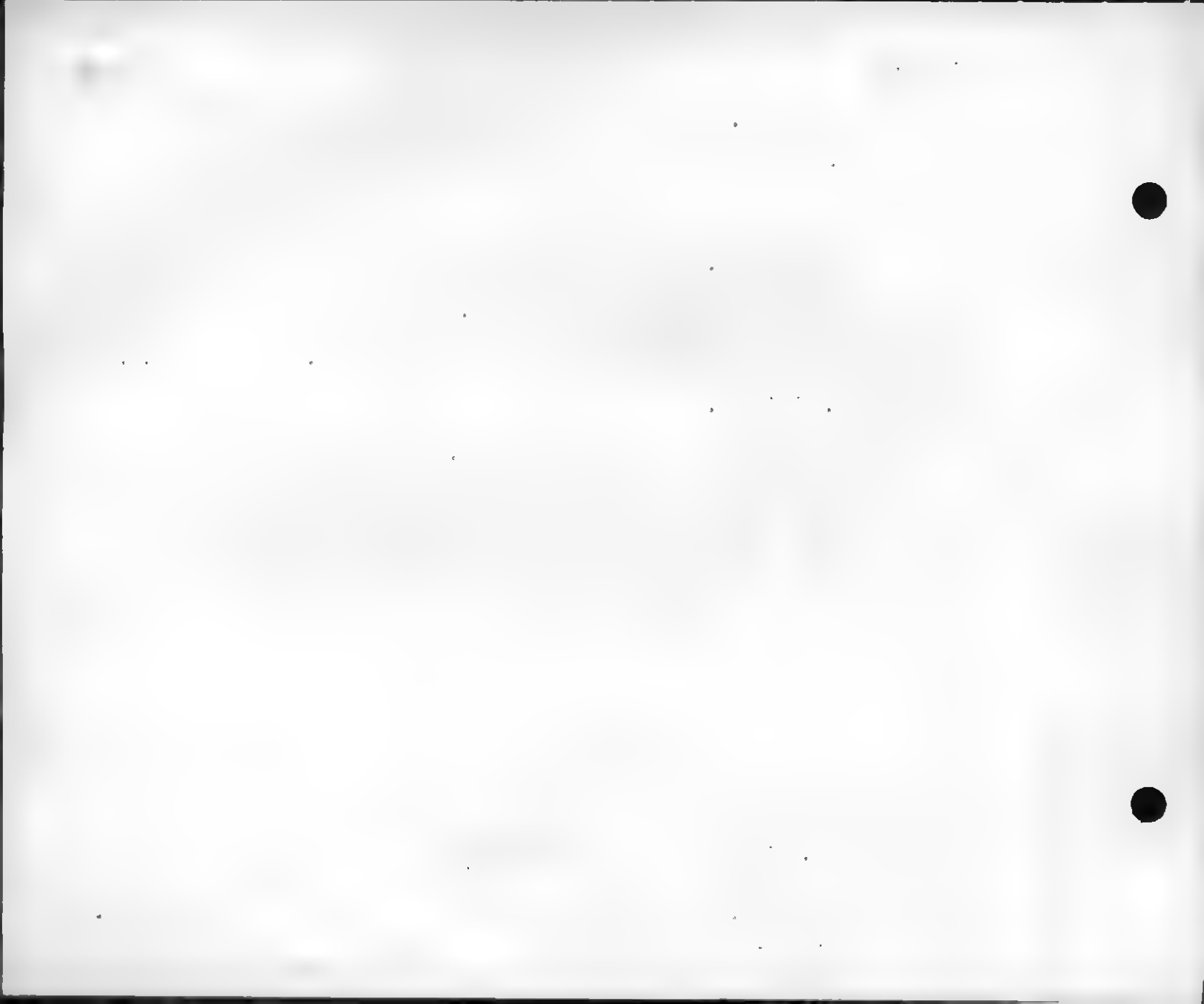
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carton papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|---|--|---|---|--|---|---|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 06391 CERTIFICATE OF DEATH 10380 | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore Co. MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | | | |
| b. CITY OR TOWN (If outside corporate limits, give RURAL or give nearest town)
Fullerton Rural | | | c. LENGTH OF STAY in lb
Lifetime | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fullerton Rural | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
7909 Belair Road | | | | | d. STREET ADDRESS
7909 Belair Road | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
Louisa A. Reider First Middle Last | | | | | 4. DATE OF DEATH
Month May Day 8 Year 1967 | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH
Nov. 8, 1907 | | 9. AGE (In years last birthday) yrs 59 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of year, even if retired)
Home maker | | 10b. KIND OF BUSINESS OR INDUSTRY
Housewife | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore Co. | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
George A. Klein Sr. | | | | | 14. MOTHER'S MAIDEN NAME
Annie Brockmeyer | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO
None | | 17. INFORMANT
John H. Reider | | | Address
7909 Belair Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic cancer, rebr, liver
1976 DUE TO Undefined primary co-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last bronchial or breast?
DUE TO (b) 1 yr?
DUE TO (c) | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State)
May 6, 1955 to 5-8-67 | | |
| 21. I certify that (I) (this hospital) attended the deceased from May 6, 1955 to 5-8-67 , that (I) (we) last saw the deceased alive on 5-8-67 , and that death occurred at 7P M, from causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE
Dr. Riger | | | | | 22b. DATE SIGNED
MAY 12 1967 | | | 22c. PHYSICIAN'S NAME (Type)
Dr. Riger | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | 23b. DATE THEREOF
May 12, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION (City or Town) (County) (State)
Kenwood Balto. Md. | |
| 24. FUNERAL DIRECTOR
Lassahn Funeral Home | | | | | ADDRESS
7401 Belair Road | | 25a. REC'D BY REGISTRAR
MAY 12 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

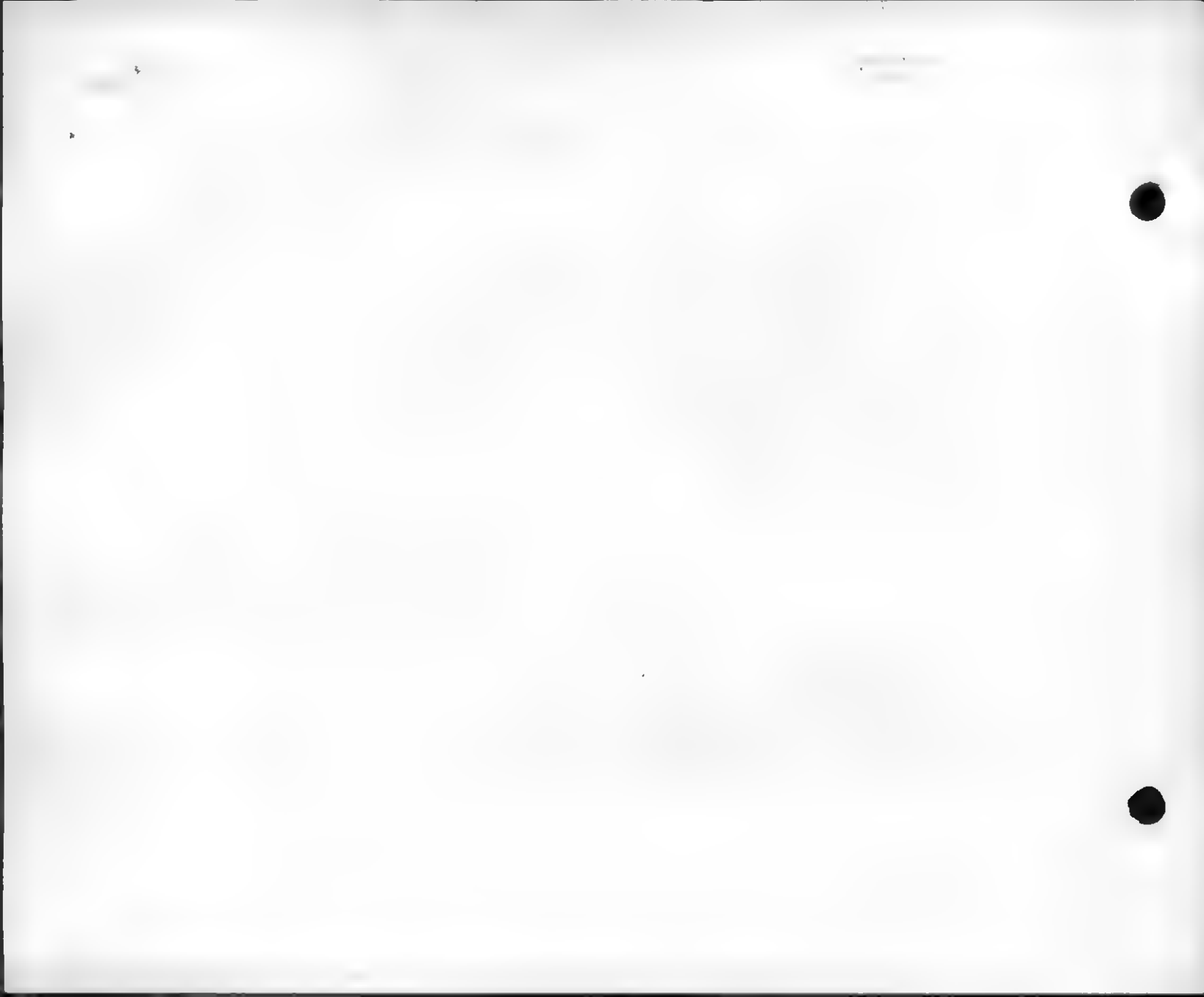
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06392

CERTIFICATE OF DEATH

06381

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN b
16 | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21206 | | d. STREET ADDRESS
6102 Hamilton Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Joseph Frederick Reihl, Jr. | | 4. DATE OF DEATH
Month May Day 22 Year 1967 | | 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
May 20, 1967 | | 9. AGE (In years past birthday)
yrs 2 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (County & State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY
USA | | 13. FATHER'S NAME
Joseph Frederick Reihl, Sr. | | 14. MOTHER'S MAIDEN NAME
Norma Helen Massey | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Hospital Records | | 18. ADDRESS
Hospital Records | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Immaturity . Respiratory distress syndrome of the Newborn
DUE TO (b) 29 hours
DUE TO (c) 29 hours | | 19. INTERVAL BETWEEN ONSET AND DEATH
29 hours | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | 20c. TIME OF INJURY Month, Day, Year
Hour 19 o.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town)
Rock Hall, Md. | | 20g. (County)
Rock Hall, Md. | | 20h. (State)
Rock Hall, Md. | | 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 20, 1967 , to May 22, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 22, 1967 , and that death occurred at 2:35 M. , from causes and on the date stated above. | | 22a. SIGNATURE
Imelda Salanio | |
| 22b. PHYSICIAN'S NAME (Type)
Imelda Salanio, M.D. | | 22c. ADDRESS
7620 York Rd., Towson, Md. 21204 | | 22d. DATE SIGNED
May 22, 1967 | | 22e. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22f. DATE SIGNED
May 22, 1967 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/23/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Wesley Chapel Cem. | | 23d. LOCATION (City or Town)
Rock Hall, Md. | | 23e. (County)
Rock Hall, Md. | |
| 23f. (State)
Rock Hall, Md. | | 23g. NAME OF CEMETERY OR CREMATORY
Wesley Chapel Cem. | | 23h. LOCATION (City or Town)
Rock Hall, Md. | | 23i. (County)
Rock Hall, Md. | | 23j. (State)
Rock Hall, Md. | |
| 24. FUNERAL DIRECTOR
J. Willis Wells | | 24a. ADDRESS
Chestertown, Md. | | 24b. REC'D BY REGISTRAR
MAY 25 1967 | | 24c. REGISTRAR'S SIGNATURE
Charles Judge | | 24d. DATE
MAY 25 1967 | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

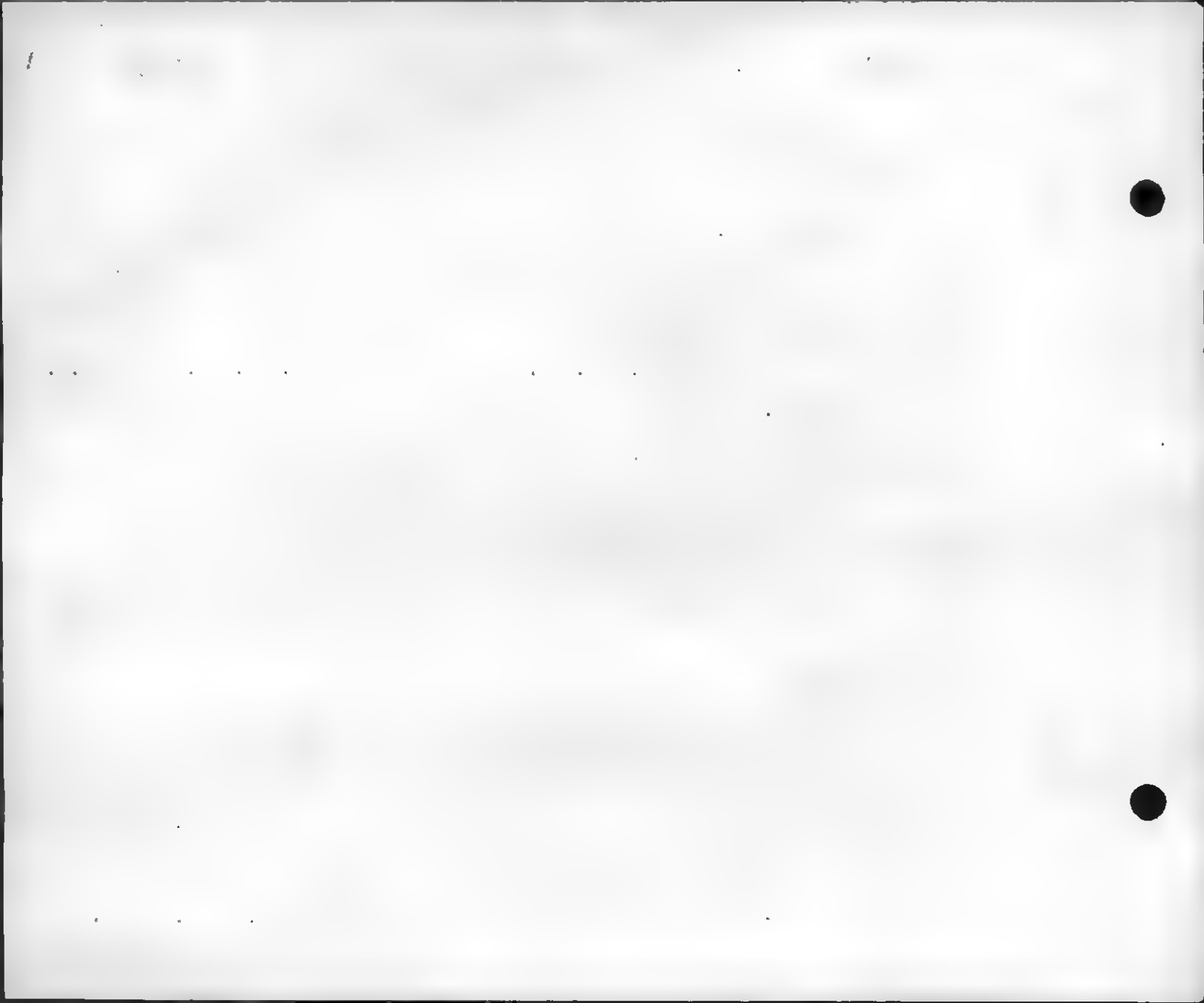
06393

CERTIFICATE OF DEATH

JE382

| | | | | | | | |
|--|---------------------------------|--|---|--|--|---|--|
| 1 PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fullerton | | | c. LENGTH OF STAY IN 1b
25yrs | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fullerton | | | d. STREET ADDRESS
4544 Ridge Road 36 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
4544 Ridge Road | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Margaret Middle Reiners Last Reiners | | | | 4. DATE OF DEATH
Month 5 Day 6 Year 19 67 | | | |
| 5 SEX
Female | 6 COLOR OR RACE
White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-2-1891 | | 9 AGE (In years lost birthday)
75 yrs | 10. IF UNDER 1 YEAR
Months 75 Days 75 Hours 75 Min. | 11. IF UNDER 24 HRS
Months 75 Days 75 Hours 75 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist | | | 10b. KIND OF BUSINESS OR INDUSTRY
Thau Mfg. Co. | | 11. BIRTHPLACE (County & State, or foreign country)
Fullerton Balto. Co. Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Henry H. Deigert | | | | 14. MOTHER'S MAIDEN NAME
Christine Michling | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | 16. SOCIAL SECURITY NO
214-20-9375A | | 17. INFORMANT Address
Mrs Gladys Schaefer 1815 Wycliffe Road 28234 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coma -
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Stroke -
DUE TO (c) Atherosclerotic Cardiovascular Disease | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
White <input type="checkbox"/> Not White <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 9-13- , 19 66 , to 6 May, 1967 that (I) (we) last saw the deceased alive on 6 May , 19 67 , and that death occurred at 10 p.m. M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
John C. Hyle | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5-8-67 | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN C. Hyle | | | | 22d. ADDRESS
7527 Belair Rd Baltimore 36 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-9-1967 | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Co. Md. | | |
| 24. FUNERAL DIRECTOR ADDRESS
Lassahn Funeral Home 7401 Belair Rd 36 | | | | 25a. REC'D BY REGISTRAR
MAY 11 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06394

10583

| | | | |
|---|------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3101 TEXAS AVE.</u> | | d. STREET ADDRESS <u>3101 TEXAS AVE.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>HELEN SYLVIA REYNOLDS</u> | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>24</u> Year <u>1967</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>APRIL 1, 1898</u> |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>BALTO., MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>WILLIAM FINCK</u> | | 14. MOTHER'S MAIDEN NAME <u>CATHERINE HAMMEL</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO.</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>FAMILY</u> | |
| 17. INFORMANT <u>SAME</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u>
11/11 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>followed surgical removal melanoma skin</u>
DUE TO (c) <u>24y.</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>8/18</u> , 19 <u>47</u> , to <u>5/22</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>5/22</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> A.M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | ADDRESS (Street, city or town, state) <u>1250 E. North Ave. Baltimore, Md. 21202</u> | |
| DATE SIGNED <u>5/26/67</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Dr. Sol Tanenbaum</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>5-27-1967</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u> | 22d. LOCATION (City, town, or county) (State) <u>TAYLOR AVE BALTO. MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Walter Conklin</u> | | ADDRESS <u>5444 BELAIR RD.</u> | |
| 24a. REC'D BY REGISTRAR <u>MAY 29 1967</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

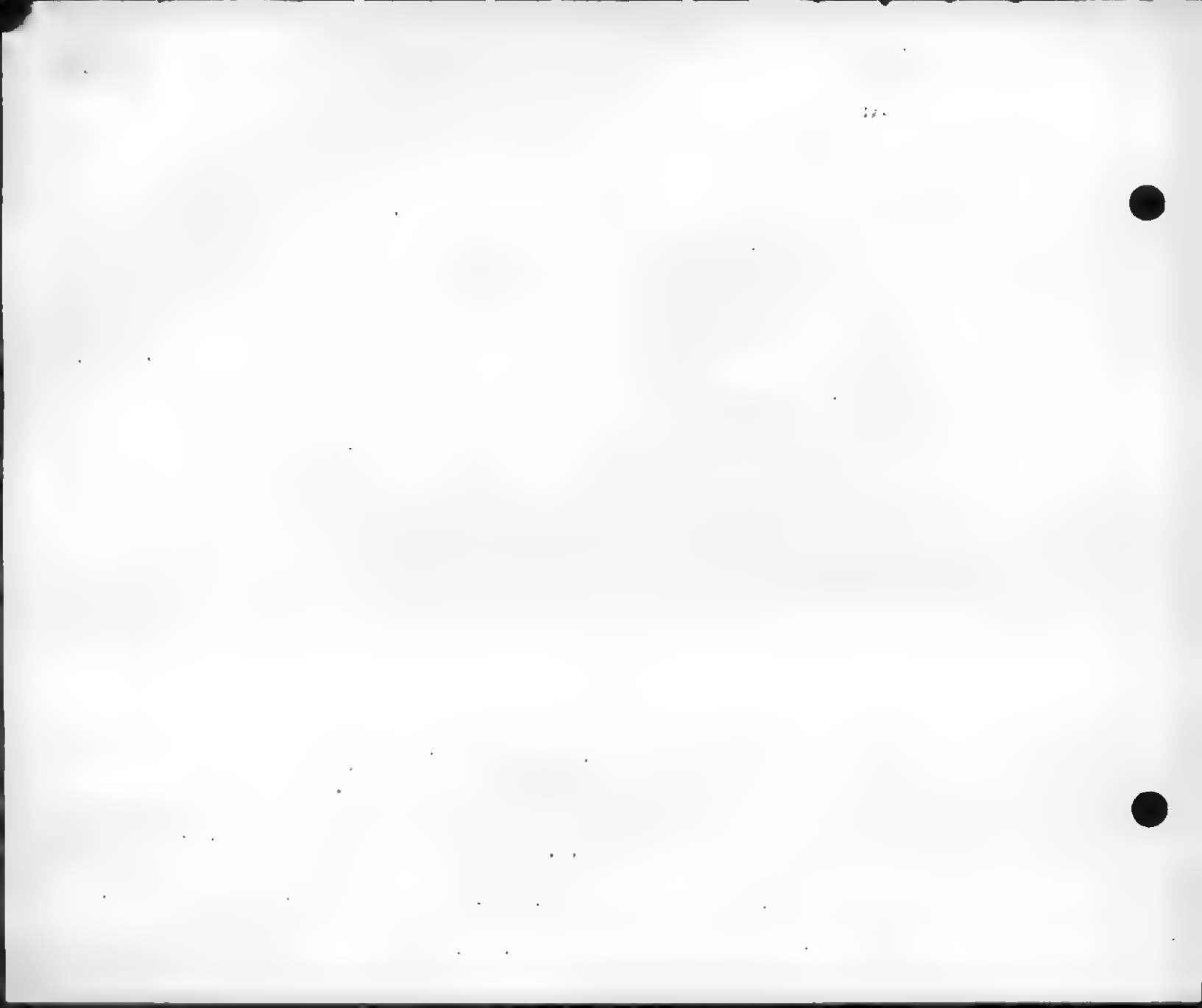


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06395
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE Maryland b. COUNTY _____ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonville | | c. LENGTH OF STAY IN ID
5 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS
912 S. Brunswick Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
William | | First William Middle J Last Riggs | | 4. DATE OF DEATH
Month May Day 9 Year 19 67 | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
May 24, 1913 | |
| 9. AGE (In years last birthday)
54 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
chauffer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
John F. Riggs | | 14. MOTHER'S MAIDEN NAME
Bessie Kane | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
220-07-5216 | | 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic carcinoma of the lungs with metastatic lesions
6.21 DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that OR (this hospital) attended the deceased from May 4, 19 67 to May 9, 19 67 , that OR (we) last saw the deceased alive on May 9, 19 67 , and that death occurred at 11:00 M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Stella Wachslar | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5-10-67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Stella Wachslar, M.D. | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/13/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard | | ADDRESS
4107 Wilkens Ave. 21229 | | 25a. REC'D BY REGISTRAR
MAY 11 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06396

Item #14 Film #638 11/1/67 p2

CERTIFICATE OF DEATH

06396

| | | | | | | | |
|---|-----------------------------|--|---------------------------------------|--|--|--|--|
| 1 PLACE OF DEATH
a COUNTY Baltimore MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE Maryland b COUNTY Baltimore | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Parkville | | | | c LENGTH OF STAY IN b
25 yrs. | | | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
3017 Edgewood ave | | | | d STREET ADDRESS
3017 Edgewood ave | | | |
| 3 NAME OF DECEASED (Type or print)
First Middle Last
Henry D. Riley | | | | 4 DATE OF DEATH
Month Day Year
May 6, 1967 | | | |
| 5 SEX
M | 6 COLOR OR RACE
W | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
Nov 26 1903 | 9 AGE (In years last birthday)
63 yrs | IF UNDER 1 YEAR
Months Days Hours Min | IF UNDER 24 HRS
Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Caretaker | | 10b KIND OF BUSINESS OR INDUSTRY
Guest Home | | 11 BIRTHPLACE (County & State, or foreign country)
Virginia | | 12 CITIZEN OF WHAT COUNTRY?
USA | |
| 13 FATHER'S NAME
William H. Riley | | | | 14 MOTHER'S MAIDEN NAME
Sarah E. RILEY Rousey | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16 SOCIAL SECURITY NO.
220-01-9492 | | 17. INFORMANT
Address
Family Records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Bronchogenic Carcinoma
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis Cardiac Vascular Disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH?
1 yr + | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 2-1 , 19 66 , to 5-6 , 19 67 , that (I) (we) last saw the deceased alive on 5-6 19 67 , and that death occurred at 3p M, from causes and on the date stated above. | | | | | | | |
| 22a SIGNATURE
John C. Hyle | | | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b DATE SIGNED
5-8-67 | |
| 22c PHYSICIAN'S NAME (Type)
John C. Hyle MD | | | | 22d ADDRESS
7527 Belair Road | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b DATE THEREOF
5/10/67 | | 23c NAME OF CEMETERY OR CREMATORY
Dulane Valley Mem. | | 23d LOCATION (City or Town) (County) (State)
Towson Balto. | |
| 24 FUNERAL DIRECTOR
C.F. EVANS & SON | | | | ADDRESS
8802 Harford road | | 25a REC'D BY REGISTRAR
MAY 11 1967 | |
| | | | | 25b REGISTRAR'S SIGNATURE
Charles Judge | | | |

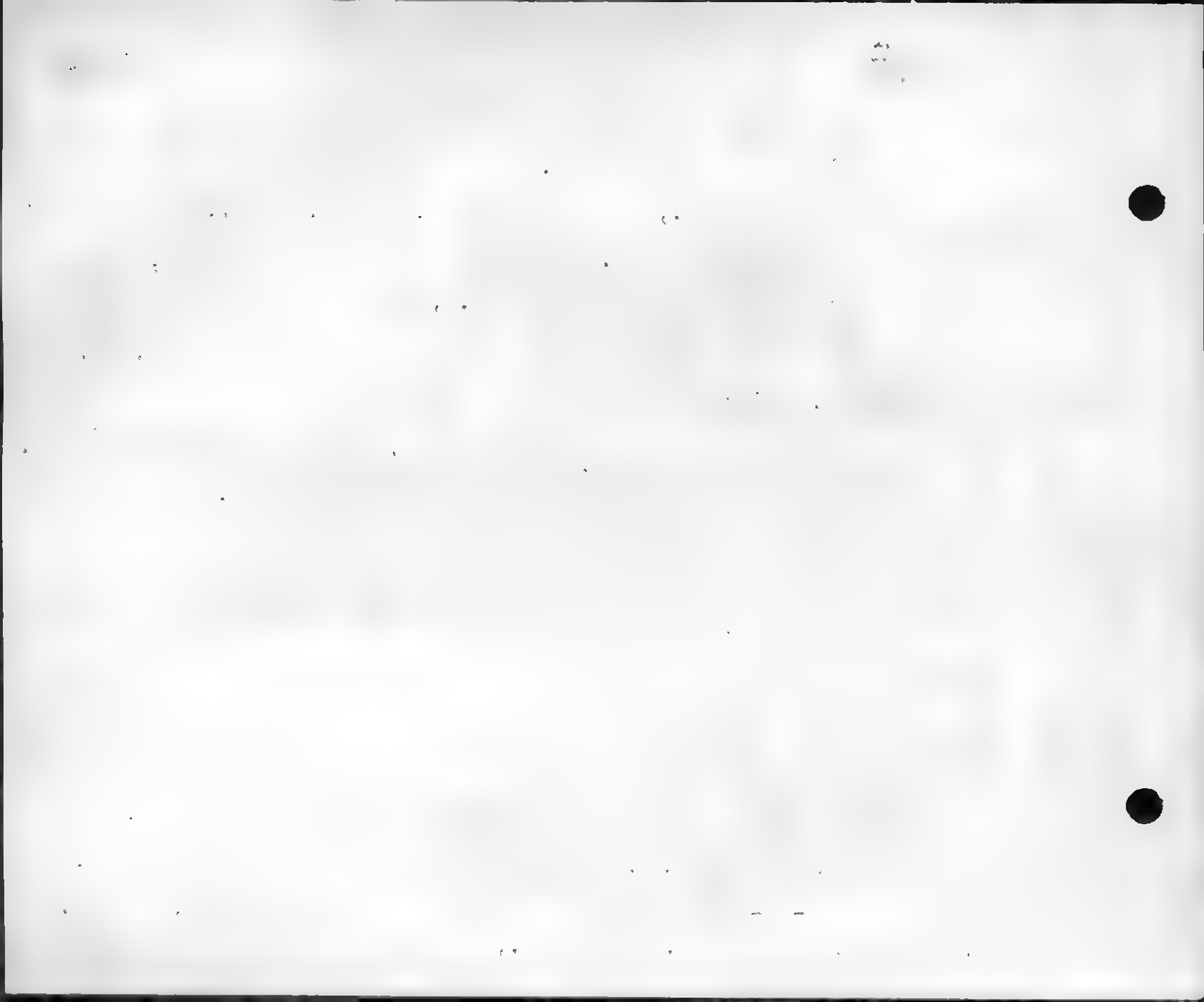


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville
c. LENGTH OF STAY IN 1b 30 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 102 Bloomsbury Ave., | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville
d. STREET ADDRESS 102 Bloomsbury Ave.,
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Irene Middle M. Last Ring | | 4. DATE OF DEATH
Month May Day 25 , Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 1, 1890 |
| 9. AGE (In years last birthday) 76 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Stephen J. Anderson | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT Virginia A. Nonemaker | | Address (12) 521 Windwood Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____
OUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH 1 yr + |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peptic ulcer - diverticulitis | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from December 6, 1950 , to May 25, 1967 , that (I) (we) last saw the deceased alive on May 8, 1967 , and that death occurred at 6 A.M. , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE John A. Nesbitt, Jr., M.D. | | 22b. DATE SIGNED 5-25-67 | |
| 22c. PHYSICIAN'S NAME (Type) John A. Nesbitt, Jr., M.D. | | 22d. ADDRESS 1009 Frederick Road, Baltimore, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5-29-1967 | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park | 23d. LOCATION (City, town or county) (State) Baltimore, Md. |
| 24. FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave., | | 25a. REC'D BY REGISTRAR MAY 29 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | |



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and any event within 72 hours after death.

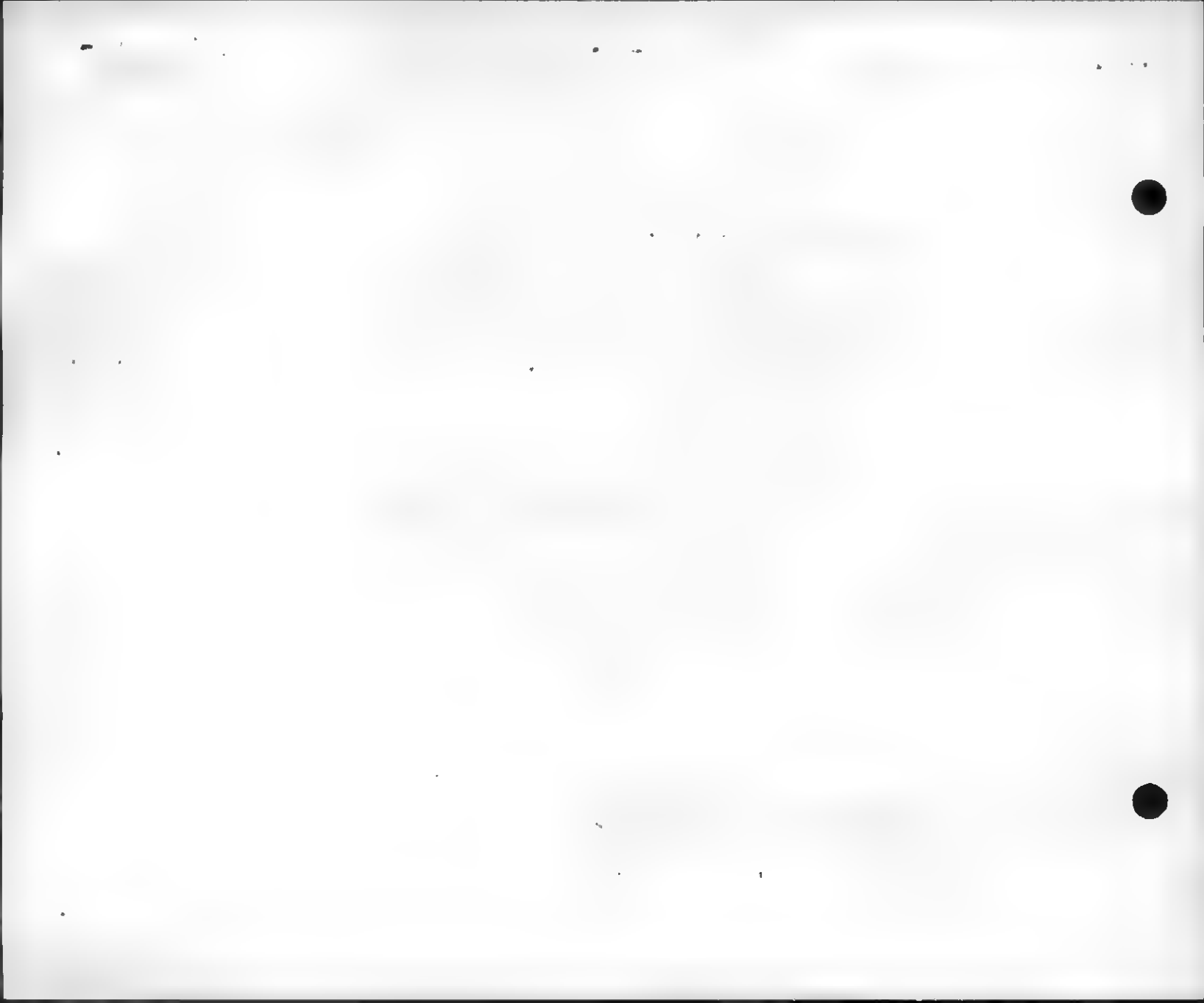
VR A15ME (5)
6M 1/67

Item #9 Film #1388-17/57 ps

06398

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|---|---------------------------------|--|-------------------------------------|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fork | | | | c. LENGTH OF STAY IN 1b
35 yrs | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Harford Road Fork, Md. | | | | d. STREET ADDRESS
Robert's Fruit Stand | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
FRANCES MARY ROBERTS | | | | 4. DATE OF DEATH
Month Day Year
5 12 1967 | | | |
| 5 SEX
Female | 6 COLOR OR RACE
White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
7-16-1909 | 9 AGE (In years last birthday)
57 yrs | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Waitress | 10b. KIND OF BUSINESS OR INDUSTRY
Bendix Co. | 11 BIRTHPLACE (State or foreign country)
New York |
| 13. FATHER'S NAME
O'Donnell | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO
213-169626 | | 17. INFORMANT
Mr Walter Roberts Address 21087 Kingsville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)
DUE TO (c)
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 0 m p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Werner U. Spitz | | EXAMINER'S NAME (Type)
WERNER U. SPITZ, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county) | | 22. DATE SIGNED
5-13-67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-16-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Bel Air Memorial Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Bel Air Md. | |
| 24. FUNERAL DIRECTOR
Lassman Funeral Home | | | | ADDRESS
7461 Bel Air Road | | 25a. REC'D BY REGISTRAR
MAY 15 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | |



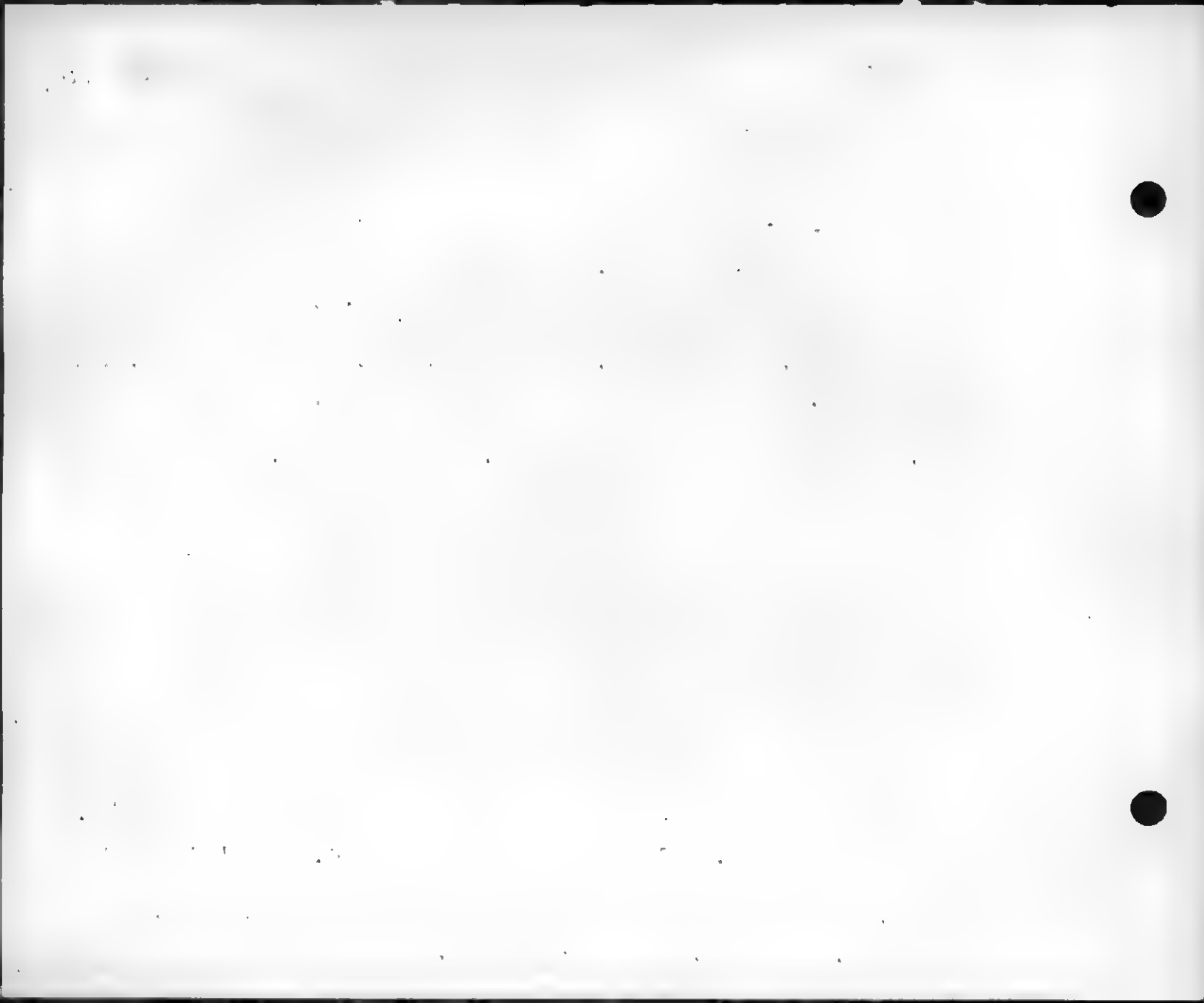
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Towson | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Lutherville | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
St. Joseph Hospital | | d. STREET ADDRESS
8504 Valley Field Rd. | |
| 3. NAME OF DECEASED (Type or print)
First Harry Middle L. Last Roff | | 4. DATE OF DEATH
Month 5 Day 23 Year 1967 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/16/1895 |
| 9. AGE (in years last birthday)
72 yrs. | | 10. BIRTHPLACE (County & State, or foreign country)
Maryland | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Harry Roff | | 14. MOTHER'S MAIDEN NAME
Alice Hall | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes. (If yes give war or dates of service) War 1 | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Ann Hessler | | Address
8504 Valleyfield rd | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congenital heart failure
DUE TO (b) Arteriosclerosis cardiovascular disease
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Nelson S. de la Paz | | 22b. DATE SIGNED
5/23/67. | |
| 22c. PHYSICIAN'S NAME (Type)
Nelson S. de la Paz | | 22d. ADDRESS
St. Joseph's Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial. | 23b. DATE THEREOF
5/26/67 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cem. | 23d. LOCATION (City, town or county) (State)
Baltimore, Md. |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, inc. 5305 Harford Rd. | | 25a. REC'D BY REGISTRAR
MAY 24 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles J. [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

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06400

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 2 Film 03-0 6/23/67 kkk

CERTIFICATE OF DEATH

06389

| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CATONSVILLE | | c. LENGTH OF STAY in lb
BALTIMORE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
FOREST HAVEN NURSING HOME | | d. STREET ADDRESS Dundalk Hotel
FOREST HAVEN NURSING HOME | |
| 3. NAME OF DECEASED (Type or print)
First MORRIS Middle ROSENFELD Last | | 4 DATE OF DEATH MAY 15, 1967
Month Day Year | |
| 5 SEX MALE | 6 COLOR OR RACE WHITE | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 73 yrs |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
STOREKEEPER | | 10b KIND OF BUSINESS OR INDUSTRY OWN | |
| 11 BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MARYLAND | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13 FATHER'S NAME AARON ROSENFELD | | 14 MOTHER'S MAIDEN NAME ELIA SIDENBERG | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES U.S. 1 ARMY | | 16 SOCIAL SECURITY NO 219-01-3661A | |
| 17 INFORMANT MR. EDWARD ROSENFELD, 913 TYSON PLACE #1 | | Address | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) DA'GIL MIA 1973
DUE TO 4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) DEAD B MYOPHASIC DYSTROPHY
DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 7/1, 1966 , to 5/15, 1967 , that (I) (we) last saw the deceased alive on 5/14, 1967 , and that death occurred at 2:45 PM , from causes and on the date stated above. | | | |
| 22a SIGNATURE DR. JOHN SHAW | | 22b DATES SIGNED 5/15/67 | |
| 22c PHYSICIAN'S NAME (Type) DR. JOHN SHAW | | 22d ADDRESS 5800 EDMONDSON AVENUE | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
BURIAL-CREMA | | 23b DATE THEREOF 5/16/67 | |
| 23c NAME OF CEMETERY OR CREMATORY LOUDEN PARK | | 23d LOCATION (City or town) (County) (State)
BALTIMORE, MARYLAND | |
| 24 FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD. | | 25a REC'D BY REGISTRAR MAY 22 1967 | |
| | | 25b REGISTRAR'S SIGNATURE J. Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
e. COUNTY <u>Baltimore</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dulaney Towson Nursing Home</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>md.</u> b. COUNTY <u>BALTIMORE</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. 12</u>
d. STREET ADDRESS <u>356 Rosebank Ave.</u> | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Jeannie McPherson</u>
5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 4. DATE OF DEATH <u>5 12 19 67</u>
8. DATE OF BIRTH <u>Dec 4 1881</u> 9. AGE (in years last birthday) <u>85</u> yrs. 10. UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u> | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | | | | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Dumbarton, Scotland</u> | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | |
| 13. FATHER'S NAME <u>Duncan McPherson</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Jeannie Mc Donald</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | | 16. SOCIAL SECURITY NO. <u>FAMILY RECORDS</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u>
DUE TO (b) <u>C Metastases to Brain</u>
DUE TO (c) <u></u> | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic</u> | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | | | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> , 19 <u>67</u> , to <u>May 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 13, 1967</u> , and that death occurred at <u>8:31</u> M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Michael J. Gandy</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | |
| 22b. DATE SIGNED <u>5/15/67</u> | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>M Paul J. Gandy</u> | | | | | | | | | |
| 22d. ADDRESS <u>5420 York Rd Baltimore</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | | | | | | |
| 23b. DATE THEREOF <u>5/15/67</u> | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEHE.</u> | | | | | | | | | |
| 23d. LOCATION (City, town or county) (State) <u>PARKVILLE, Md.</u> | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>John Burns, Towson Md.</u> | | | | | | | | | |
| 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | |
| DATE <u>MAY 16 1967</u> | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

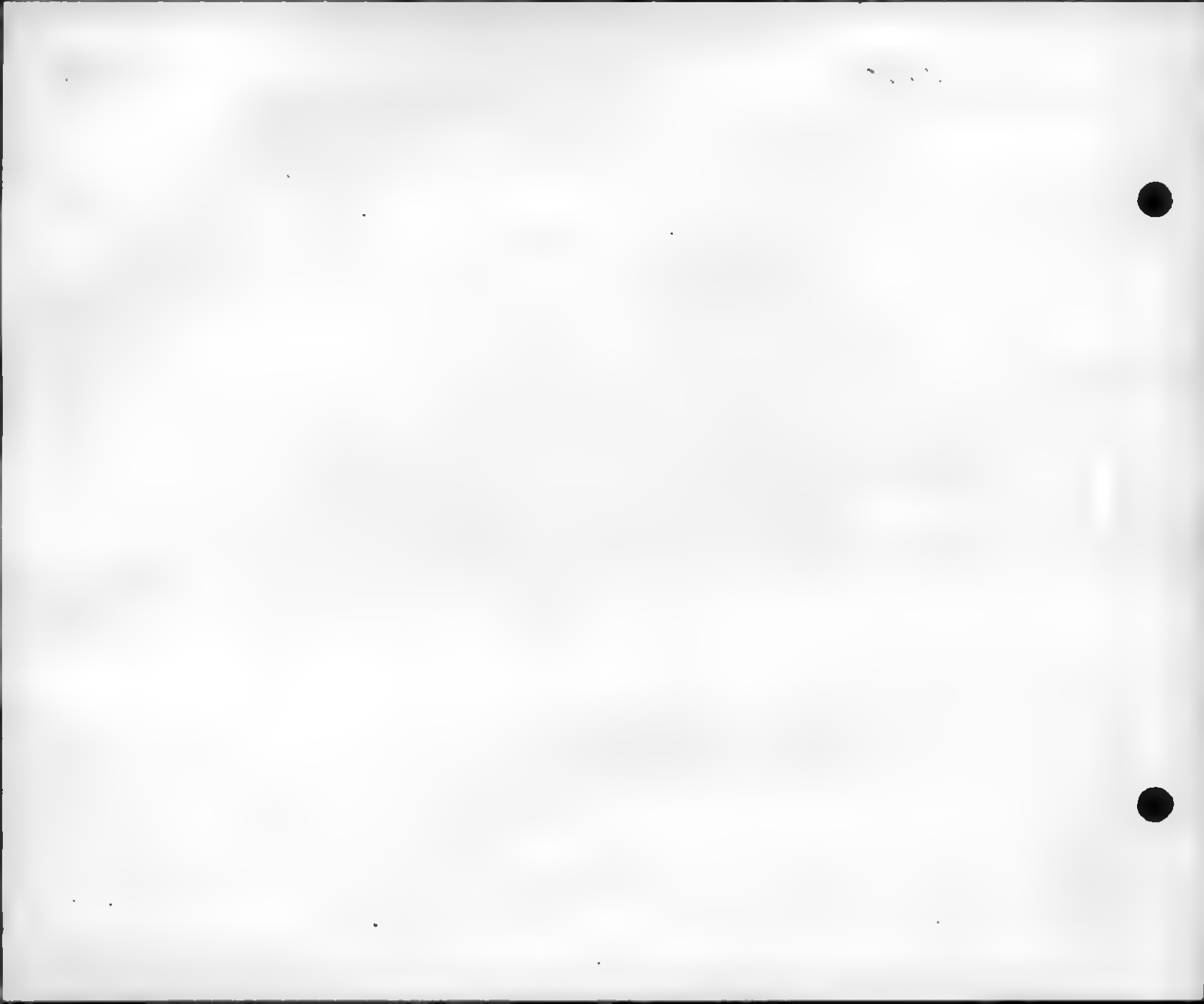
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| | | | |
|--|-------------------------------------|---|------------------------------------|
| 1 PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | c. LENGTH OF STAY IN 1b
<u>Baltimore</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>7808 Brevort Rd</u> | | d. STREET ADDRESS
<u>7808 Brevort Rd</u> | |
| 3 NAME OF DECEASED (Type or print)
First <u>Alma</u> Middle <u>D.</u> Last <u>Schaefer</u> | | 4 DATE OF DEATH
Month <u>MAY</u> Day <u>25</u> Year <u>1967</u> | |
| 5 SEX
<u>Female</u> | 6 COLOR OR RACE
<u>White</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
<u>2-3-1913</u> |
| 9 AGE (In years last birthday)
<u>54</u> yrs | | 10 UNDER 1 YEAR
Months <u>54</u> Days <u>54</u> Hours <u>54</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>TAILORING</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Baltimore</u> | |
| 11 BIRTHPLACE (County & State, or foreign country)
<u>Baltimore</u> | | 12 CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>George J. Dolle</u> | | 14 MOTHER'S MAIDEN NAME
<u>Kessner</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)
<u>No</u> | | 16 SOCIAL SECURITY NO
<u>John D. Schaefer - 7807 Brevort Rd #7</u> | |
| 17 INFORMANT
<u>John D. Schaefer - 7807 Brevort Rd #7</u> | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>(1) Carcinoma - Colon with metastasis</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Glenoma - Both eyes</u>
(c) <u>- 1 yr.</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>8 months</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>None</u> | | 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>19</u> o.m. p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 18</u> , 19 <u>66</u> , to <u>May 25</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>May 25</u> , 19 <u>67</u> , and that death occurred at <u>6:45</u> M, from causes and on the date stated above | | | |
| 22a. SIGNATURE
<u>Earl L. Chambers</u> M.D. | | 22b. DATE SIGNED
<u>5/27/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Earl L. Chambers</u> | | 22d. ADDRESS
<u>4108 Liberty Hts Baltimore, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>5-29-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Dulaney Valley Memorial Gardens - Cockeysville, Md</u> | |
| 24. FUNERAL DIRECTOR
<u>Elsworth Armacost - 4600 Liberty Hts Ave</u> | | 25a. REC'D BY REGISTRAR
<u>MAY 31 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



06403

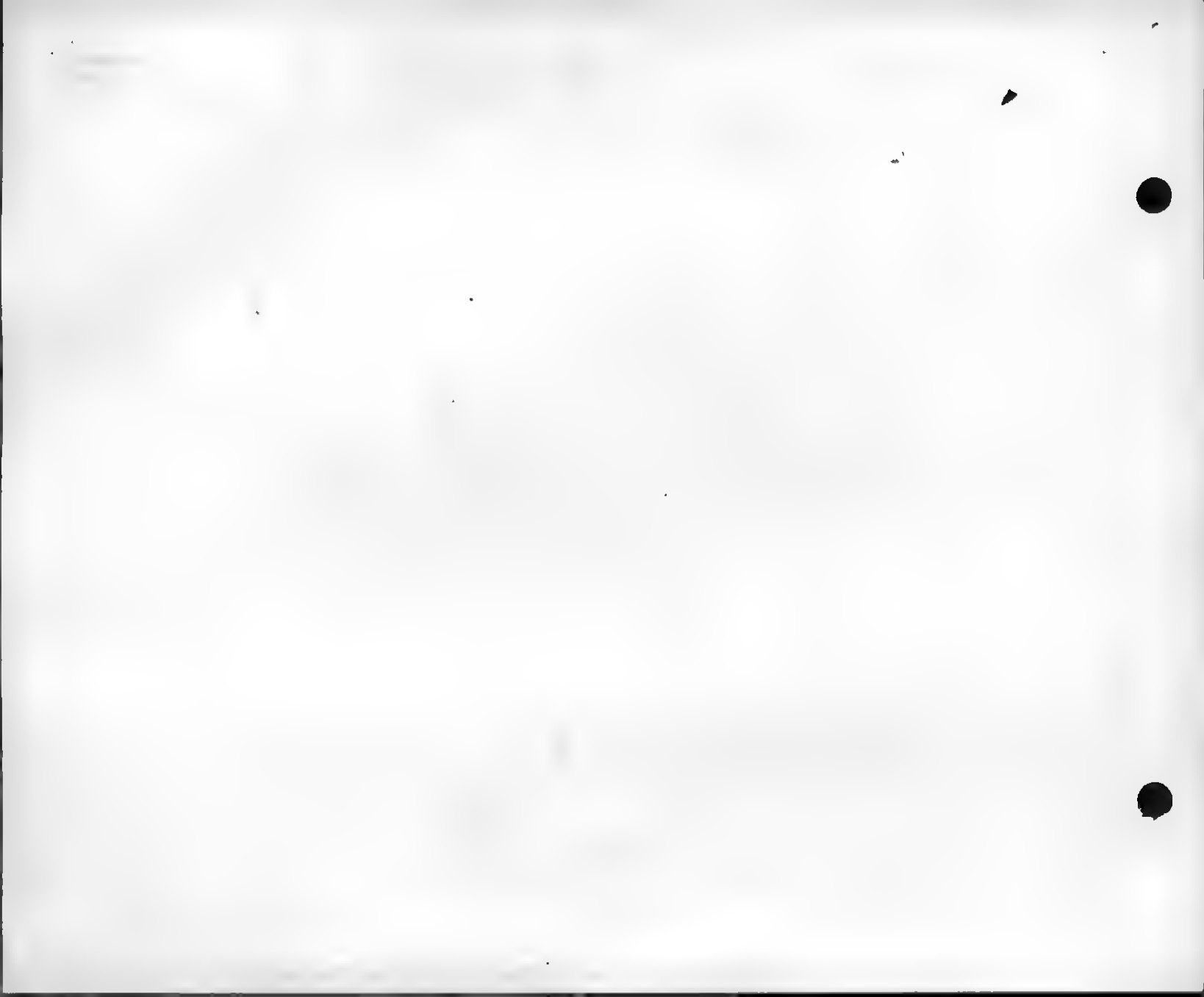
CERTIFICATE OF DEATH

2002

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>---</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Randallstown</u> | | c. LENGTH OF STAY in lb
<u>1 day</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> <u>21215</u> | | d. STREET ADDRESS
<u>2721 Cyburn Ave</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Baltimore County Hospital</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>NATHAN (Norman) R. Scheer</u> | | 4. DATE OF DEATH
Month <u>May</u> Day <u>28</u> Year <u>1967</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11-15-02</u> |
| 9. AGE (In years last birthday)
<u>64</u> yrs | | 10. UNDER 1 YEAR IF UNDER 24 HRS
Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min <u>---</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>MACHINIST</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Retired</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Russia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Reuben Scheer</u> | | 14. MOTHER'S MAIDEN NAME
<u>Pannie Karasik</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>NO YES</u> <u>WW 1 Army</u> <u>2/2-09-8/06</u> | | 17. INFORMANT
Address
<u>Mrs. Betty Scheer, 2721 Cyburn Avenue</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>pressure myocardial infarction</u>
DUE TO (b) <u>Coronary artery thrombosis</u>
DUE TO (c) <u>pswd.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
<u>12 hrs</u>
<u>12 hrs</u>
<u>YEARS</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>---</u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work
Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5-27</u> , 1967, to <u>5-28</u> , 1967, that (I) (we) last saw the deceased alive on <u>5-28-67</u> and that death occurred at <u>8:10</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Angela A. Pop</u> | | 22b. DATE SIGNED
<u>5-28-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>RNGCCTA TO PAID</u> | | 22d. ADDRESS
<u>Edis</u> | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>5/29/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Hebrew friendship</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JUN 6 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Wm. J. Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06404

CERTIFICATE OF DEATH

15793

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert in carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---|---|---|
| 1 PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson
c. LENGTH OF STAY IN 1b 5 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor N. Home | | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md.
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville
d. STREET ADDRESS 1719 Greenspring Dr.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) Frederick William Scheller
First Middle Last | | 4 DATE OF DEATH May 31, 1967
Month Day Year | |
| 5 SEX M | 6 COLOR OR RACE Cauc. | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH June 25, 1886
9. AGE (in years last birthday) 80 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor, C.&P. Telephone Co. | | 10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md. | |
| 11. BIRTHPLACE (County & State, or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frederick William Scheller | | 14. MOTHER'S MAIDEN NAME Margaret E. Wilson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO 212 05 0612 | |
| 17. INFORMANT Mrs. Mary Harvey, Lutherville, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
4321 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 10 YRS | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from May 1967 , to 5/31, 1967 , that (I) (we) lost the deceased alive on May 1967 , and that death occurred on 5/31, 1967 at 2:00 P.M. from causes on and on the date stated above. | | | |
| 22a. SIGNATURE William A. Pillsbury | | 22b. DATE SIGNED 6-1-67 | |
| 22c. PHYSICIAN'S NAME (Type) William A. Pillsbury | | 22d. ADDRESS 2060 York Rd., Timonium, Md. | |
| 23a. BURIAL, CREMATION, BURIAL (Specify) | 23b. DATE THEREOF June 3, 67 | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial | 23d. LOCATION (City or Town) (County) (State) Parkville, Baltimore, Md. |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. | | 25a. REG'D BY REGISTRAR JUN 5 1967
DATE | |
| | | 25b. REGISTRAR'S SIGNATURE Richard J. Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. The permit should be removed, and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06405

CERTIFICATE OF DEATH

06394

| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
c. LENGTH OF STAY IN 1b Life | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | d. STREET ADDRESS 9630 Alda Drive
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print)
First Henry Middle C. Last Schoeberlein | | 4 DATE OF DEATH
Month May Day 1 Year 1967 | |
| 5 SEX Male | 6. COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/31/1904 |
| 9 AGE (In years last birthday) 63 yrs | | IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY Crown Cork & S | |
| 11 BIRTHPLACE (County & State, or foreign country) Baltimore | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13 FATHER'S NAME John Schoeberlein | | 14. MOTHER'S MAIDEN NAME Fredricka Boehner | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-01-5428 | |
| 17. INFORMANT Family records | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intraventricular hemorrhage, left hemisphere of brain
DUE TO (b) Atherosclerotic heart disease with hypertension.
DUE TO (c) 4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19
p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that 10 (this hospital) attended the deceased from May 1, 1967 , to May 1, 1967 , that 10 (we) last saw the deceased alive on May 1, 1967 , and that death occurred at 9:05 p.m. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Juana S. Cockburn | | 22b. DATE SIGNED May 2, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Juana S. Cockburn, M.D. | | 22d. ADDRESS 7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 5/5/67 | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park Balto. | 23d. LOCATION (City or Town) (County) (State) Md. |
| 24. FUNERAL DIRECTOR C.F. EVANS & SON | | 25a. REC'D BY REGISTRAR Charles Judge | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | DATE MAY 3 1967 | |



THE HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

Item 2 Film G388 5/11/67 kk

1. PLACE OF DEATH
a. COUNTY **G B M C. County Baltimore** MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson

c. LENGTH OF STAY IN 1b
4

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Greater Baltimore Medical Center

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE **MARYLAND** b. COUNTY **Baltimore**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lutherville, Md. 21114

d. STREET ADDRESS **Princess Isseena Hotel**

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First **Mabel** Middle **C** Last **Schuchart.**

4. DATE OF DEATH
Month **MAY** Day **7** Year **1967**

5. SEX **Female** 6. COLOR OR RACE **Cau** 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH **2/18/85** 9. AGE (In years last birthday) **82** yrs. 10. FUND 1 YEAR IF UNDER 24 HRS. Months **4** Days **4** Hours **4** Min.

11a. USUAL OCCUPATION (Give kind of work done during last 12 months, even if retired) **Housewife** 11b. KIND OF BUSINESS OR OCCUPATION **HOUSEWIFE**

12. BIRTHPLACE (County & State, or foreign country) **Baltimore, Maryland** 13. CITIZEN OF WHAT COUNTRY? **U.S.A.**

14. FATHER'S NAME **Joseph Linthicum** 15. MOTHER'S MAIDEN NAME **Smith**

16. WAS DECEASED IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 17. SOCIAL SECURITY NO. **143-05-4288** 18. INFORMANT **PATIENTS CHART** Address

19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Cardiac arrest**
DUE TO (b) **Congestive heart failure**
DUE TO (c) **Respiratory difficulty secondary to**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **Abdominal distension by fluid due to paralytic ileus**

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

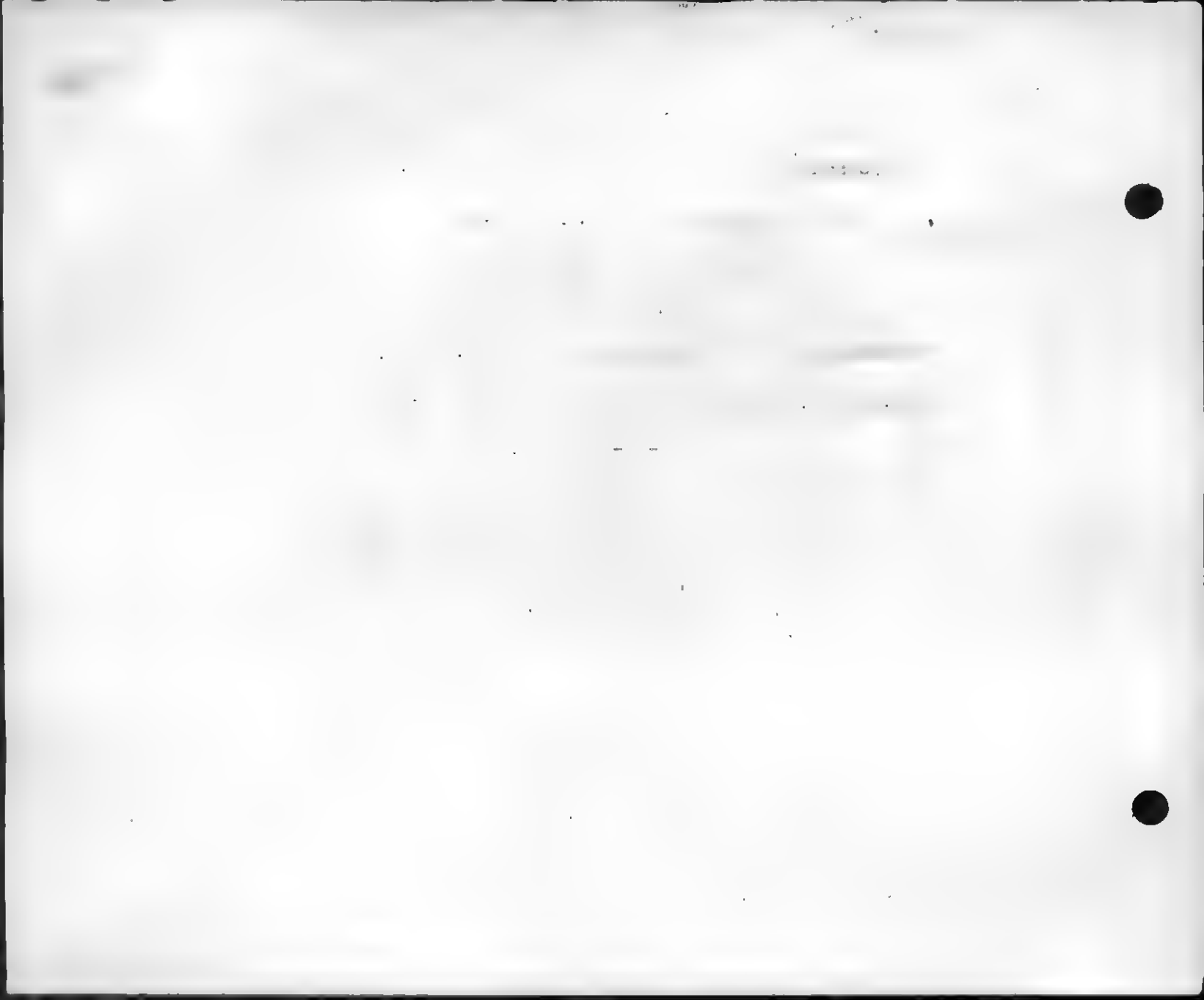
21. I certify that (I) (this hospital) attended the deceased from **1967**, to **1967**, that (I) (we) last saw the deceased alive on **MAY 3** 1967, and that death occurred at **3:45** A.M., from the causes and on the date stated above.

22a. SIGNATURE **Seock, e. chang** M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ 22b. DATE SIGNED **May 7, 67**

22c. PHYSICIAN'S NAME (Type) **G B M C** 22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **5/10/67** 23c. NAME OF CEMETERY OR CREMATORY **Druid Ridge Cemetery** 23d. LOCATION (City, town or county) (State) **Pikesville, Md.**

24. FUNERAL DIRECTOR **Wm. F. Tichner & Sons** ADDRESS **Baltimore, Md. north 2nd St.** 25a. REC'D BY REGISTRAR **Charles Judge** 25b. REGISTRAR'S SIGNATURE **Charles Judge** DATE **MAY 8 1967**



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

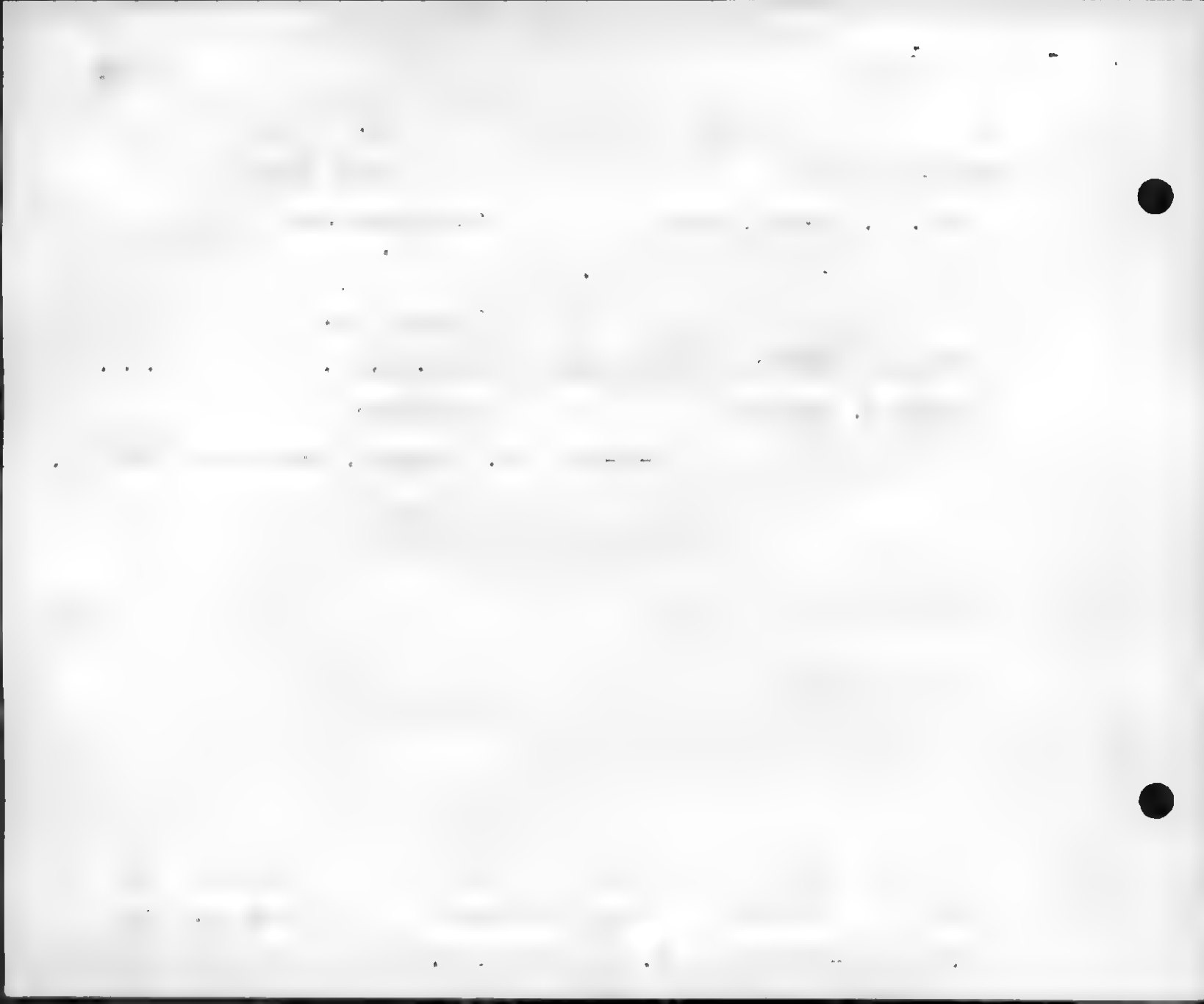
CERTIFICATE OF DEATH

06407

06506

| | | | | | | | |
|---|------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE COUNTY GEN HOSP | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission)
a. STATE Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural-Randallstown | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Randallstown 21133 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Balt. Co. General Hospital | | | | d. STREET ADDRESS
3705 Cassen Road | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last Jr.
CHARLES L. SCHWARTZ | | | | 4. DATE OF DEATH
Month Day Year
5 10 1967 | | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
77 3/4/1890 Yrs. | 9. AGE (In years last birthday)
69 yrs. | IF LINDER 1 YEAR
Months Days Hours Min | IF LINDER 24 HRS
Months Days Hours Min | |
| 10a. OCCUPATION (Give kind of work done during most of working life, even if retired)
Stationary Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY
Cold Storage | | 11. BIRTHPLACE (County & State, or foreign country)
Balt. Co. Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles L. Schwartz | | | | 14. MOTHER'S M.A.DEN NAME
Lydia Raver | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO
212-22-4776 | | 17. INFORMANT Address
Mrs. Florence L. Schwartz-3705 Cassen Rd. Randallstown | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CORONARY THROMBOSIS
DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 5/10, 1967 to 5/10, 1967 that (I) (we) last saw the deceased alive on 5/10, 1967 , and that death occurred at 7 P.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Mariando A. Tolentino M.D. | | | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
5/10/67 | |
| 22c. PHYSICIAN'S NAME (Type)
MARIANDO A. TOLENTINO | | | | 22d. ADDRESS
301 ST. PAUL ST. BALTIMORE 21202 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/13/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Pikesville, Md. 21208 | |
| 24. FUNERAL DIRECTOR
Loring Byers-8728 Liberty Rd. Randallstown, Md. | | | | 25a. REC'D BY REGISTRAR
MAY 15 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in agreement, within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cause papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|---|--|---|---|---|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville
c. LENGTH OF STAY IN 1b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1101 Hemsley Court | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville, 21093
d. STREET ADDRESS 1101 Hemsley Court
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print)
Marie C. Scotney | | | 4. DATE
DEATH May 2 1967 | | 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Secretary | | | 10b. KIND OF BUSINESS OR INDUSTRY
Bendix Corp. | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. AGE (in years last birthday) 50 yrs.
IF UNDER 1 YEAR: Months 5 Days 10 Hours 17 Min. 16 | | |
| 13. FATHER'S NAME
William A. Kammerer | | | 14. MOTHER'S MAIDEN NAME
Mary V. Collins | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. 213-01-1501 | | |
| 17. INFORMANT
Herbert M. Scotney | | | Address
(Same) | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Breast
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 1101
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from April 1967 to May 2 1967 , that (I) (we) last saw the deceased alive on May 2 1967 , and that death occurred at 10 P M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
William H. Fusting | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
5-4-67 | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. William H. Fusting | | | | | 22d. ADDRESS
4230 Loch Raven Blvd. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
5/6/1967 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION (City, town or county) (State)
Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | | | 25a. REC'D BY REGISTRAR
DATE 5 1967 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06403

CERTIFICATE OF DEATH

1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|--|-------------------------|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>ESSEX</u> | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>ESSEX</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>417 VOGTS LANE</u> | | | | d. STREET ADDRESS
<u>417 VOGTS LANE</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First <u>EMANUEL</u> Middle <u>G.</u> Last <u>SHAPIRO</u> | | | | 4. DATE OF DEATH
Month <u>MAY</u> Day <u>19</u> Year <u>1967</u> | | | |
| 5. SEX
<u>M</u> | | 6. CO. OR OR RACE
<u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>SEPT. 21, 1902</u> | |
| 9. AGE (In years lost birthday)
<u>64</u> yrs | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RET.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>N.Y.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | 13. FATHER'S NAME
<u>JOSEPH SHAPIRO</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>?</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO
<u>167-28-5214</u> | | | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>HYPERTENSIVE CARDIO-VASCULAR DISEASE</u>
DUE TO
(c) <u>DISEASE</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>11 YEARS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>APR. 13, 1956</u> , to <u>MAY 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAY 12, 1967</u> , and that death occurred at <u>6:45 A.M.</u> , from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Joseph Miceli</u> | | | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED
<u>5/19/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JOSEPH MICELI, M.D.</u> | | | | 22d. ADDRESS
<u>108 S. TAYLOR AVE ESSEX, MD 21221</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>5/22/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Fountain Park</u> | | 23d. LOCATION (City or town) (County) (State)
<u>Balto, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>J. H. Connelly Sr.</u> | | | | ADDRESS
<u>300 mace</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 23 1967</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06470

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16399

| | | | | | | | |
|---|-----------------------------|---|--|---|---|---|---|
| 1 PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived if institution or residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
On Way to St. Joseph Hospital | | | | e. STREET ADDRESS
1640 Thetford Road | | | |
| 3 NAME OF DECEASED (Type or print)
First James Middle Coleman Last Shipley, Sr. | | | | 4 DATE OF DEATH
Month 5 Day 23 Year 1967 | | | |
| 5 SEX
M | 6 COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
12/23/21 | 9 AGE (In years, months, days)
45 yrs | 10 UNDER 1 YEAR
Months 5 Days 23 Hours 19 Min 67 | 11 UNDER 24 HRS
Months 5 Days 23 Hours 19 Min 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Radio Engineer | | | 10b. KIND OF BUSINESS OR INDUSTRY
Bendix Radio Corp. | | 11 BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12 CITIZEN OF WHAT COUNTRY?
USA |
| 13 FATHER'S NAME
John William Shipley, Sr. | | | 14 MOTHER'S MAIDEN NAME
Margaret Francis Gilbert | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes | | | 16 SOCIAL SECURITY NO.
220-07-5652 | | 17 INFORMANT
Family records | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Due to (c) Due to | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 o.m. p.m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Charles F. O'Donnell | | | | 22. DATE SIGNED
5/23/67 | | | |
| EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b. DATE THEREOF
May 26, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | | 23d. LOCATION (City or town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
John Burns Sons | | | | 25a. REC'D BY REGISTRAR
TOWSON | | | |
| 25b. REGISTRAR'S SIGNATURE
John Burns Sons | | | | 25c. REGISTRAR'S SIGNATURE
John Burns Sons | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06411

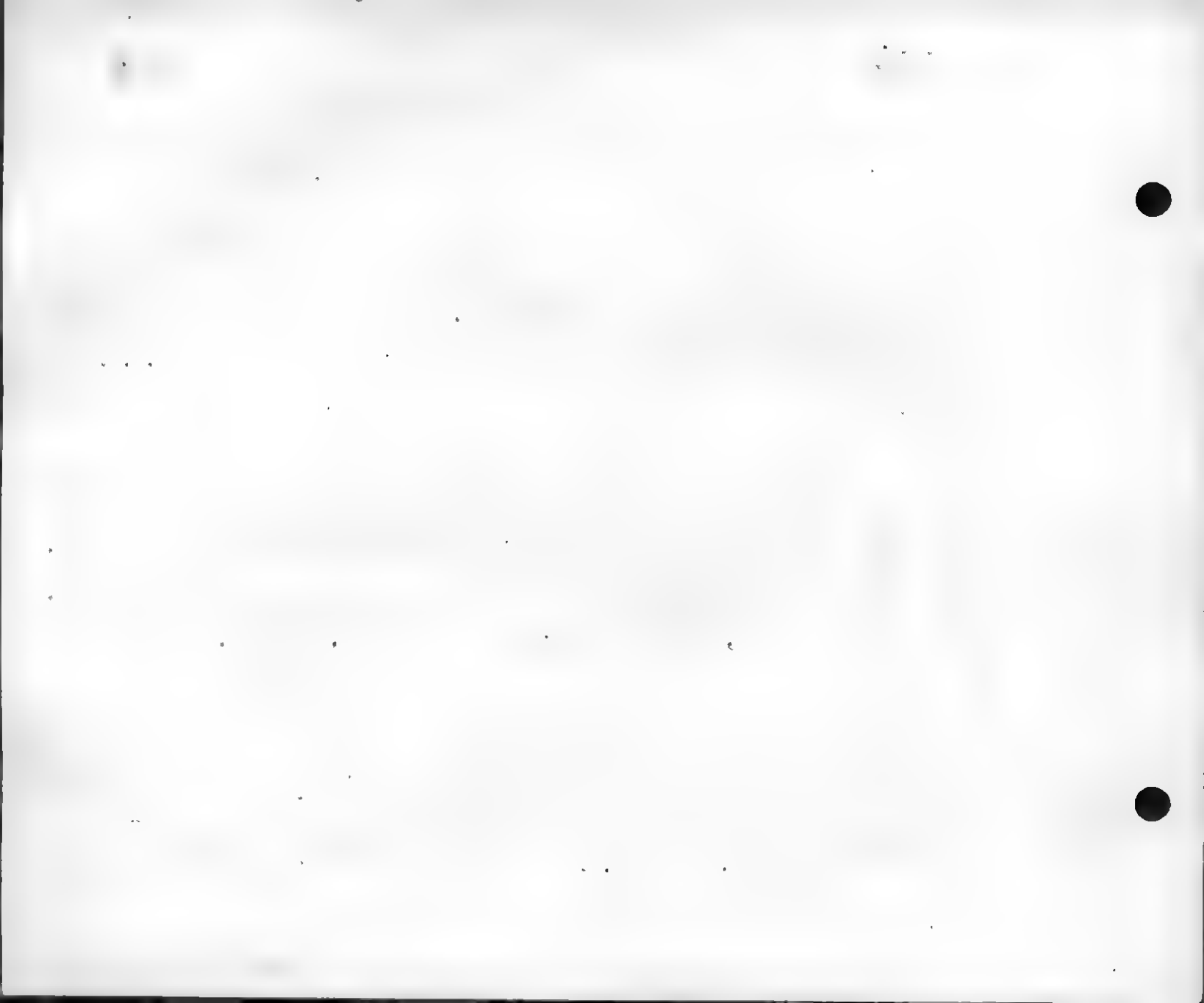
CERTIFICATE OF DEATH

06100

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission)
a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
2yr9mth 21dys | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | e. STREET ADDRESS
6707 Eade Street | |
| 3. NAME OF DECEASED (Type or print)
First Pearl Middle B Last Shumate | | 4. DATE OF DEATH
Month May Day 8 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 7, 1900 |
| 9. AGE (In years last birthday) yrs.
66 | | 10. IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min 0 | |
| 10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Isaac Brown | | 14. MOTHER'S MAIDEN NAME
Rebecca Caffee | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
579-03-0349D | |
| 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO
(b) Arteriosclerotic cardiovascular Heart Dis
DUE TO
(c) Arteriosclerosis, Generalized, senile | | INTERVAL BETWEEN ONSET AND DEATH
acute
3 yrs.
3 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Decubitus Ulcers, Sacrum and right heel, Inf. with P.Aerugin | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from July 17, 1964 , to May 8, 1967 , that (I) (we) last saw the deceased alive on May 8, 1967 , and that death occurred at 7:15 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Anthony J. Young</i> | | 22b. DATE SIGNED
5-9-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | 22d. ADDRESS
Spring Grove State Hospital
Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-12-1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Washington Hall | | 23d. LOCATION (City or Town) (County) (State)
Fort Meade | |
| 24. FUNERAL DIRECTOR
Matthew 131-1166 St. S.E. D.C. | | 25a. REC'D BY REGISTRAR
DATE MAY 12 1967 | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

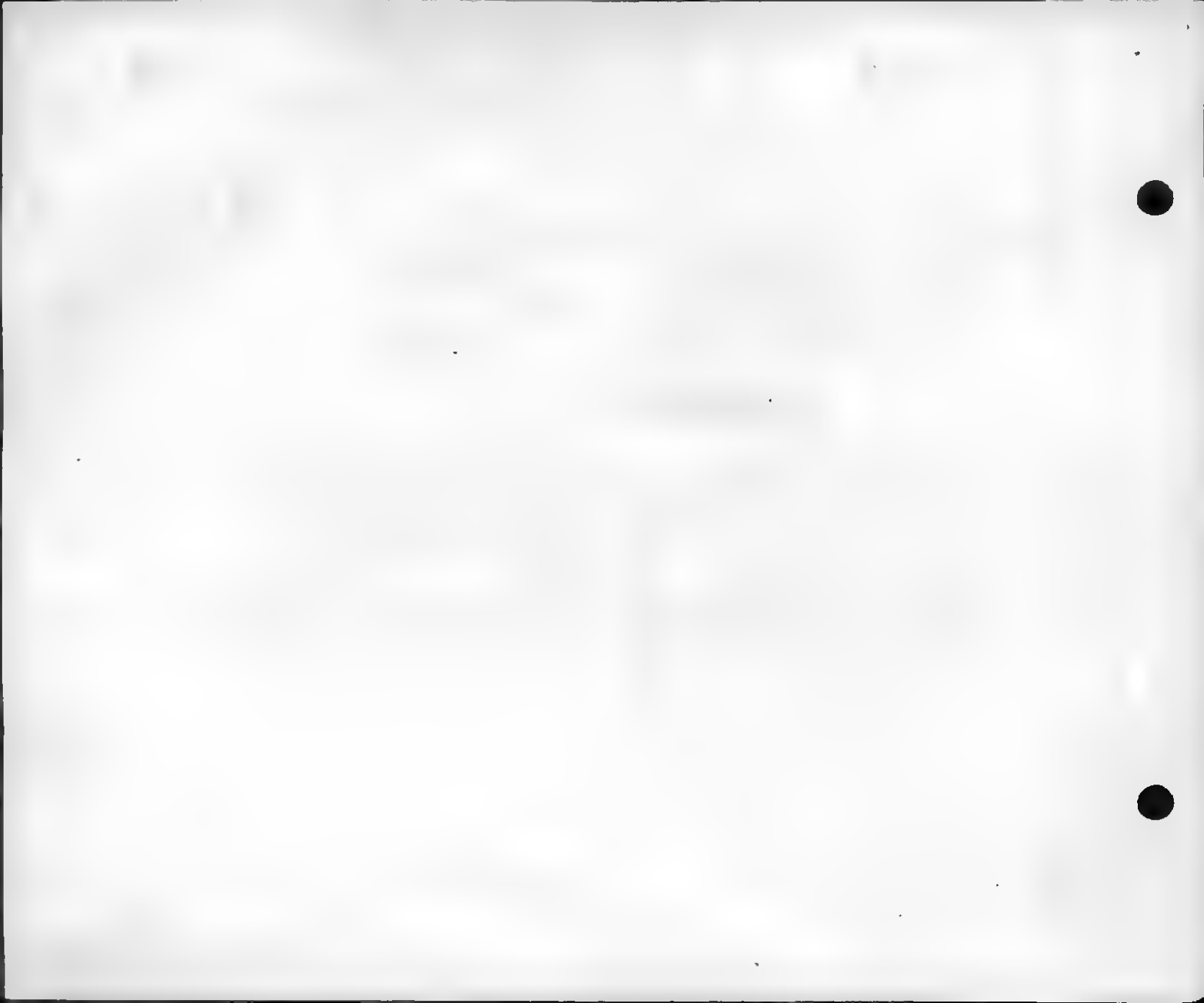
CERTIFICATE OF DEATH

06412

06401

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO.</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALL TOWN</u>
c. LENGTH OF STAY IN 1b <u>8 DAYS</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTO COUNTY HOSPITAL</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u>
d. STREET ADDRESS <u>5417 CRUMER Avenue</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>KATHERINE</u> First Middle Last <u>SIEGEL</u> | | 4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-11-89</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> |
| 11. BIRTHPLACE (County & State, or foreign country) <u>XXXXXXXXXXXX LATVIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>LEVI</u> XXXXXXXXXXXX <u>KIRSON</u> | | 14. MOTHER'S MAIDEN NAME <u>BESSIE</u> <u>Sprachson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO <u>NO</u> | |
| 17. INFORMANT <u>MORTON H. PERRY, ESQ.,</u> Address <u>EQUITABLE BLDG.</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>GENERALIZED ARTEROSCLEROSIS</u>
DUE TO _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO _____
(c) _____ | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>CA OF PANCREAS WITH METASTASIS; DEHYDRATION</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4/23/67</u> , 19 <u>67</u> , to <u>5/1/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/1/67</u> , 19 <u>67</u> , and that death occurred at <u>11:20 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Nathan Needle</u> M.D. | | 22b. DATE SIGNED <u>5-1-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>NATHAN NEEDLE</u> | | 22d. ADDRESS <u>PARK HEIGHTS AVENUE</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>5/3/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL</u> | 23d. LOCATION (City or Town) _____ (County) _____ (State) <u>BALTIMORE, MARYLAND</u> |
| 24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. IN C., 6010 REIST., RD.</u> | | 25a. REC'D BY REGISTRAR <u>MAY 5 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

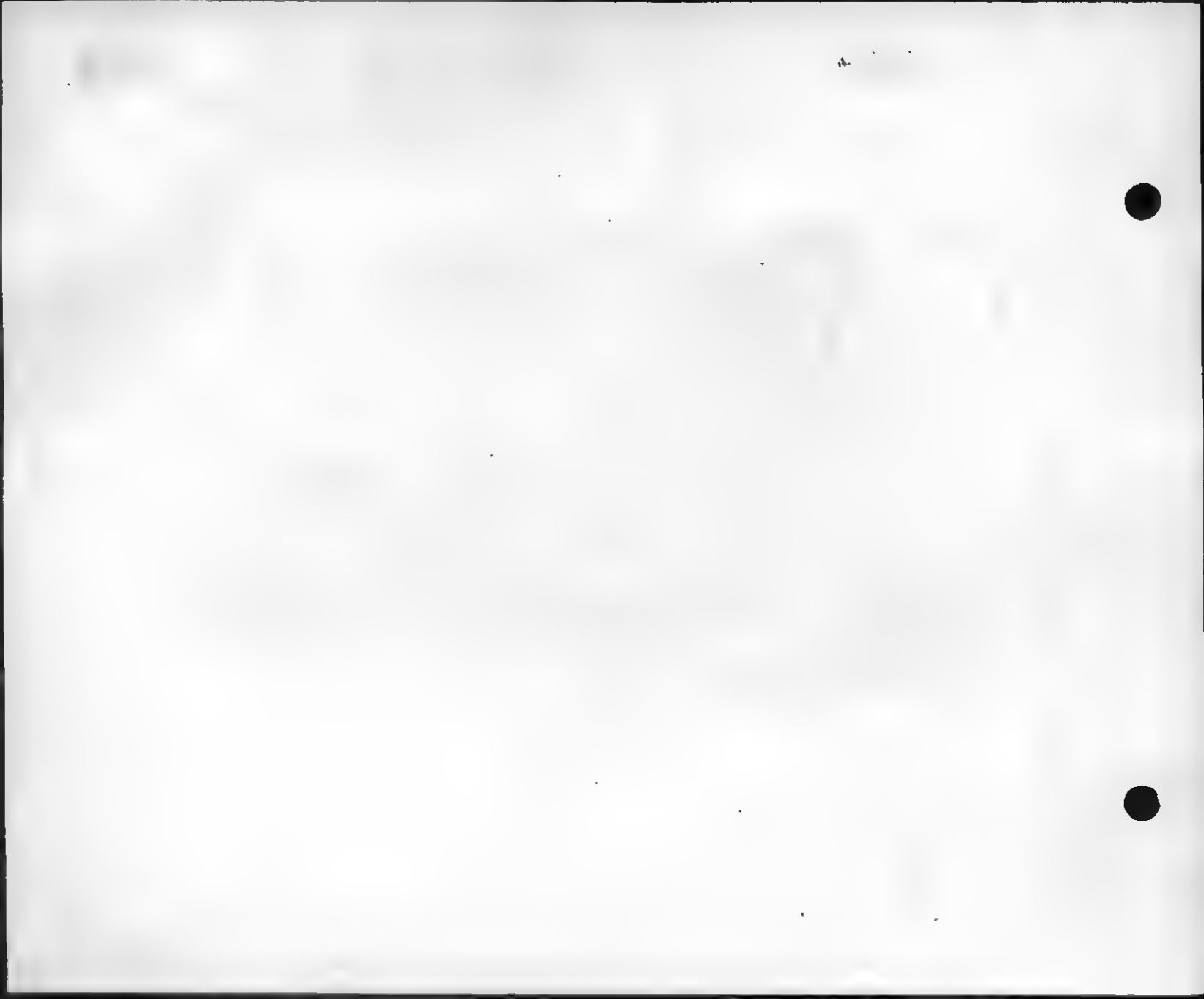


06413

Item 8 Palm G389-5/41/37

MEDICAL CERTIFICATION

VR A15 (4
15M 4-64



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06414

06103

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE <u>md.</u> b. COUNTY <u>Balt. City</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | c. LENGTH OF STAY IN IS
<u>Unknown</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Greater Baltimore Med. Center</u> | | d. STREET ADDRESS
<u>3016 Christopher Ave</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Rose</u> Middle <u>Estelle</u> Last <u>Silverthorne</u> | | 4. DATE OF DEATH
Month <u>5</u> Day <u>24</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Cau</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>10/10/1876</u> |
| 9. AGE (In years last birthday)
<u>90</u> yrs | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Concord, Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>William Wilson</u> | | 14. MOTHER'S MAIDEN NAME
<u>Churn</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO
<u>223-70-6995</u> | |
| 17. INFORMANT
<u>Virginia Stevens</u> | | Address
<u>3016 Christopher Ave</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>C.V.A.</u>
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) <u> </u>
(c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u> </u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u> </u> | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
<u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | 20f. (City or town) (County) (State)
<u> </u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4-14</u> , 19 <u>67</u> , to <u>5-24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-24</u> 19 <u>67</u> , and that death occurred at <u>2:45AM</u> , from causes and on the date stated above | | | |
| 22a. SIGNATURE
<u>R. K. CHILLAR</u> | | 22b. DATE SIGNED
<u>5/24/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>RAM K. CHILLAR</u> | | 22d. ADDRESS
<u>GTR. BALTIMORE MED. CENTER BALTIMORE, MD.</u> | |
| 23a. BURIAL, CREMATION, or other disposal (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>5-27-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>NELSON CEMETERY</u> | 23d. LOCATION (City or town) (County) (State)
<u>BALTIMORE CITY WDC MD.</u> |
| 24. FUNERAL DIRECTOR
<u>Robert N. Watson</u>
<u>ROBERT A. WATSON</u> | | 25a. RECORD BY REGISTRAR
<u>MAY 29 1967</u> | |



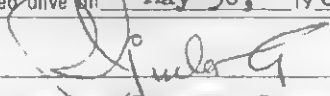

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

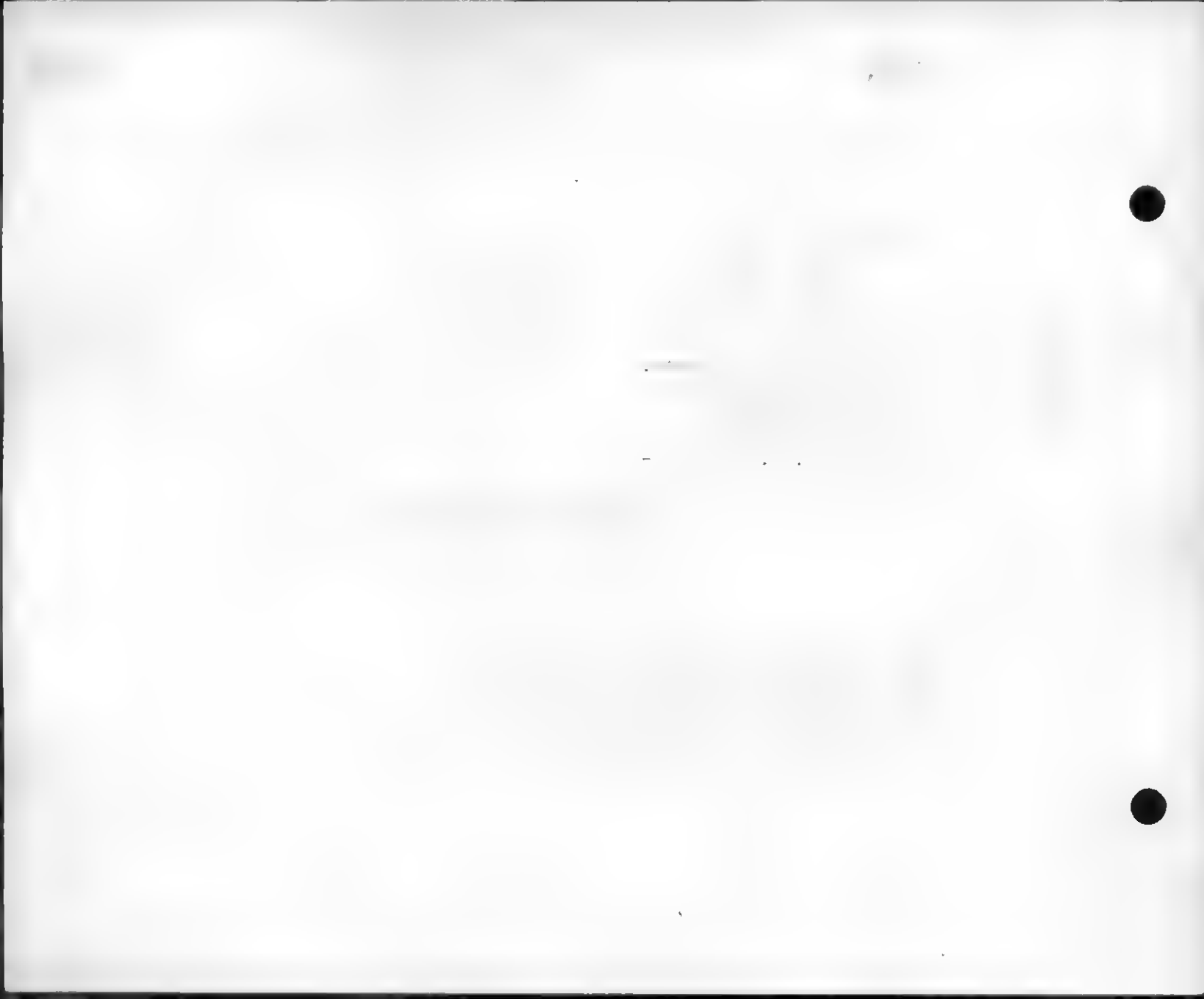
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06415
JF104

| | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN Hrs.
Timonium, 21093 | | 2. USUAL RESIDENCE (Where deceased lived, if inst. in Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Timonium, 21093 | | d. STREET ADDRESS
16 Northwood Dr. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Andrew | | First Middle Last
SKERCHEK | | 4. DATE OF DEATH
Month Day Year
May 30, 1967 | | 5. SEX
Male | | 6. COLOR OR RACE
White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12-4-1907 | | 9. AGE (in years last birthday)
59 yrs | | F UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Butcher | | 10b. KIND OF BUSINESS OR INDUSTRY
Owner- | | 11. BIRTHPLACE (County & State, or foreign country)
New Jersey | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
John Skerchek | | | | 14. MOTHER'S MAIDEN NAME
Pearl Herila | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes W. W. TWO | | 16. SOCIAL SECURITY NO.
145-09-9452 | | 17. INFORMANT
Natalie Skerchek, Same as # 2 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute hemorrhagic pancreatitis.
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Acute pulmonary edema | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 30, 1967 , to May 30, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 30, 1967 , and that death occurred at 11:45M , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
 | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
May 31, 1967 | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Reynaldo Orjuela-Gomez, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
June 3, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Clover Leaf Park | | 23d. LOCATION (City or Town) (County) (State)
Woodbridge, New Jersey | | | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204 | | | | 25a. REC'D BY REGISTRAR
JUN 5 1967 | | 25b. REGISTRAR'S SIGNATURE
 | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06416

CERTIFICATE OF DEATH

06105

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|----------------------------------|--|---|--|---|--|--|
| 1 PLACE OF DEATH
a COUNTY BALTIMORE MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE MARYLAND b COUNTY BALTIMORE | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | | c LENGTH OF STAY IN 1b
4 DAYS | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
EDGEMERE BALTIMORE COUNTY | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | d STREET ADDRESS
3229 LYNCH ROAD | | e IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print)
First JOSEPH Middle NMI Last SMITH | | | | 4 DATE OF DEATH
Month MAY Day 10 Year 19 67 | | | |
| 5 SEX
MALE | 6. COLOR OR RACE
WHITE | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
2/21/96 | | 9 AGE (In years last birthday)
71 yrs | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER, RETIRED | | 10b KIND OF BUSINESS OR INDUSTRY
STEEL CO. | | 11 BIRTHPLACE (County & State, or foreign country)
MARYLAND EDGEMERE BALTO. COUNTY | | 12 CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13 FATHER'S NAME
FRANK STACHOWSKI | | | | 14. MOTHER'S MAIDEN NAME
CATHERINE TOMCZEWSKI | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
YES WW I | | 16. SOCIAL SECURITY NO
213 09 15 41 | | 17. INFORMANT
CLINICAL RECORDS VAH FORT HOWARD, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF THE LUNG, RIGHT, WITH METASTASIS
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
DAYS
UNKNOWN | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 5/6/1967 to 5/10/1967 , that (I) (we) last saw the deceased alive on 5/10/1967 , and that death occurred at p. M. from causes and on the date stated above. | | | | | | | |
| 22a SIGNATURE
<i>Carmelita A. Cendana</i> M.D. | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED
5-10-67 | |
| 22c. PHYSICIAN'S NAME (Type)
CARMELITA A. CENDANA, M.D. | | 22d ADDRESS
VAH, FORT HOWARD, MARYLAND | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b DATE THEREOF
5/15/67 | | 23c NAME OF CEMETERY OR CREMATORY
HOLY ROSARY CEMETERY | | 23d LOCATION (City or Town) (County) (State)
BALTIMORE COUNTY, MARYLAND | |
| 24 FUNERAL DIRECTOR
John J. Duda | | | | 25a REC'D BY REGISTRAR
MAY 15 1967 | | 25b REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

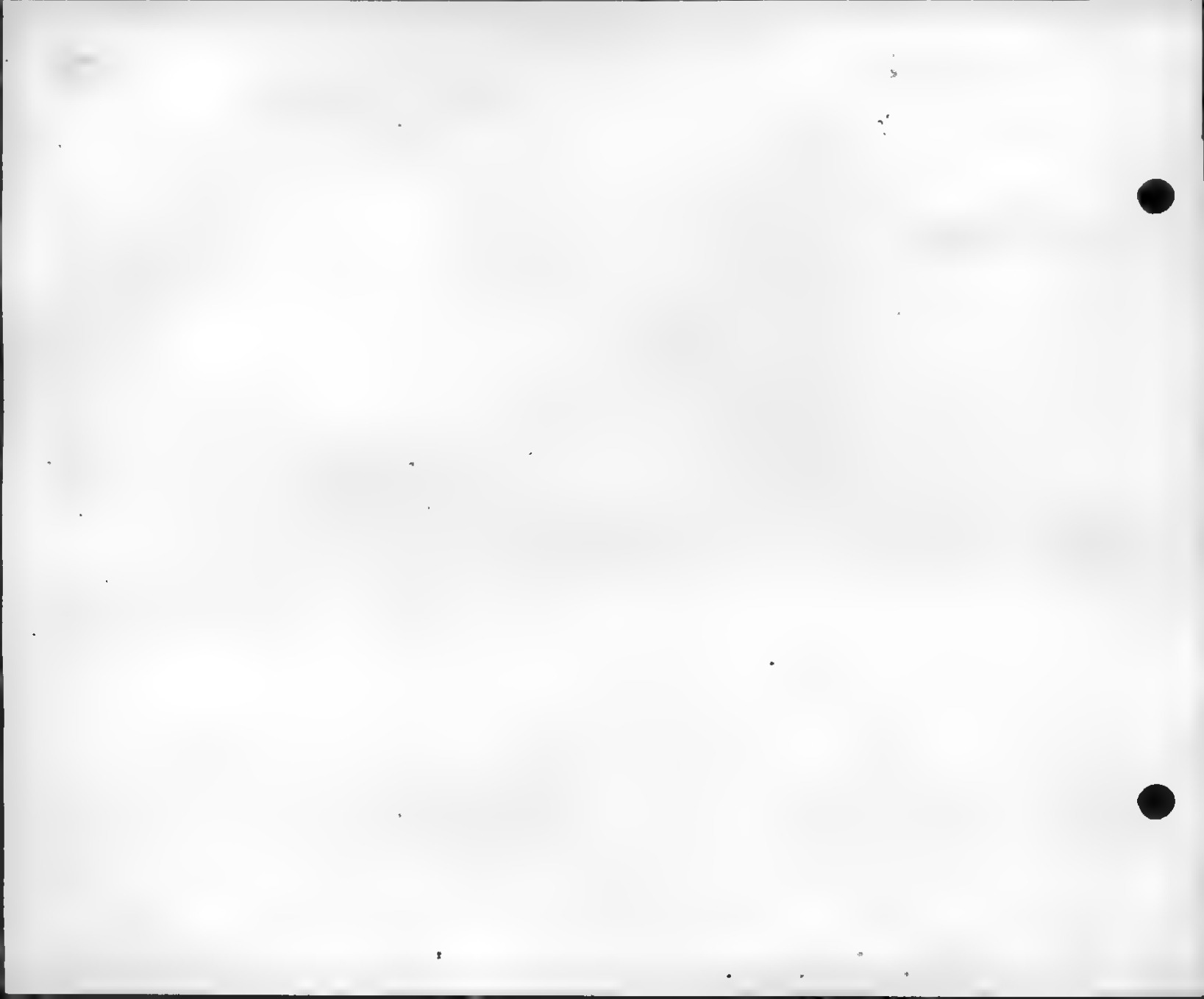
06417

CERTIFICATE OF DEATH

15406

| | | | | | | | | | | | | |
|--|---------------------------------|--|----------------------------------|--|--|--|--|--|--|--|--|--|
| 1 PLACE OF DEATH
a. COUNTY Baltimore
<div align="center">MARYLAND</div> | | | | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)
a. STATE Maryland b. COUNTY ✓ | | | | | | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cottonville | | | c LENGTH OF STAY IN 1b | | c CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)
Baltimore | | | | | | | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Paradise Nursing Home | | | | d STREET ADDRESS
6205 Marietta Ave. | | e IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED
(Type or print) LILLIAN E. SMITH
<div align="center">First Middle Last</div> | | | | 4. DATE OF DEATH
<div align="center">Month Day Year</div> 5 16 1967 | | | | | | | | |
| 5 SEX
Female | 6 COLOR OR RACE
White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
3/6/83 | | 9 AGE (In years last birthday)
84 yrs | IF UNDER 1 YEAR
Months Days Hours Min | | | | | | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12 CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | |
| 13 FATHER'S NAME
Jacob Nelson | | | | 14 MOTHER'S MAIDEN NAME
Ida Lukun | | | | | | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | | 16 SOCIAL SECURITY NO | | 17. INFORMANT
Nelson E. Smith-6205 Marietta Ave.
<div align="right">Address</div> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
<div align="center">IMMEDIATE CAUSE (a)</div> <div align="center">DUE TO</div> <div align="center">(b)</div> <div align="center">DUE TO</div> <div align="center">(c)</div> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
10 yrs.
5 yrs.
3 months | | | | | | |
| | | | | | | | Generalized Arteriosclerosis
Chronic Bronch Syndrome
Decubiti Multiple | | | | | |
| | | | | | | | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| | | | | | | | 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f (City or town) (County) (State) | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/13/67 to 5/16/67 , that (I) (we) last saw the deceased alive on 5/15/67 and that death occurred at 2:10 A M, from causes and on the date stated above. | | | | | | | | | | | | |
| 22a. SIGNATURE
W.E. McGloth M.D. | | | | 22b. DATE SIGNED
5/17/67 | | 22c. PHYSICIAN'S NAME (Type)
W.E. McGloth M.D. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/19/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial Pk | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | | |
| 24. FUNERAL DIRECTOR
Robert C. Altenburg - 6009 Harford Rd.
Funeral Home, Inc. | | | | 25a. REC'D BY REGISTRAR
DATE MAY 18 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1

M

06418

06407

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--------------------------|--|---------------------------------|--|---|--|--|
| 1 PLACE OF DEATH
a. COUNTY <u>BALTO</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>116 WOODLAWN AVE</u> | | | | d. STREET ADDRESS
<u>116 WOODLAWN AVE</u> | | | |
| 3 NAME OF DECEASED (Type or print) <u>RUTH J. SMULLEN</u> | | | | 4 DATE OF DEATH <u>5/27</u> 19 <u>67</u> | | | |
| 5 SEX <u>F</u> | 6 COLOR OR RACE <u>W</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/25/08</u> | | 9 AGE (In years last birthday) <u>59</u> yrs. | 10. IF UNDER 1 YEAR
Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>NEW YORK</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>HARRY BOLTON</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>FLORENCE M. MULLEN</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO | | 17. INFORMANT
<u>GEORGE C. SMULLEN</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>terminal phase of Metastatic</u>
DUE TO (b) <u>C of Breast</u>
DUE TO (c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/27/1966</u> to <u>5/28/1967</u> that (I) (we) last saw the deceased alive on <u>5/23/1967</u> , and that death occurred at <u>2:00 P.M.</u> from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Adnan Sonmez</u> | | | | 22b. DATE SIGNED
<u>5/29/1967</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>ADNAN SONMEZ</u> | |
| 22d. ADDRESS
<u>1011 Frederick Road Balt. Md 21278</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>CREMATION</u> | | 23b. DATE THEREOF
<u>5/30/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>LOUDBON PARK</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>BALTO MD</u> | |
| 24. FUNERAL DIRECTOR
<u>E.S. MALNABR</u> | | | | 25a. REC'D BY REGISTRAR
<u>21228</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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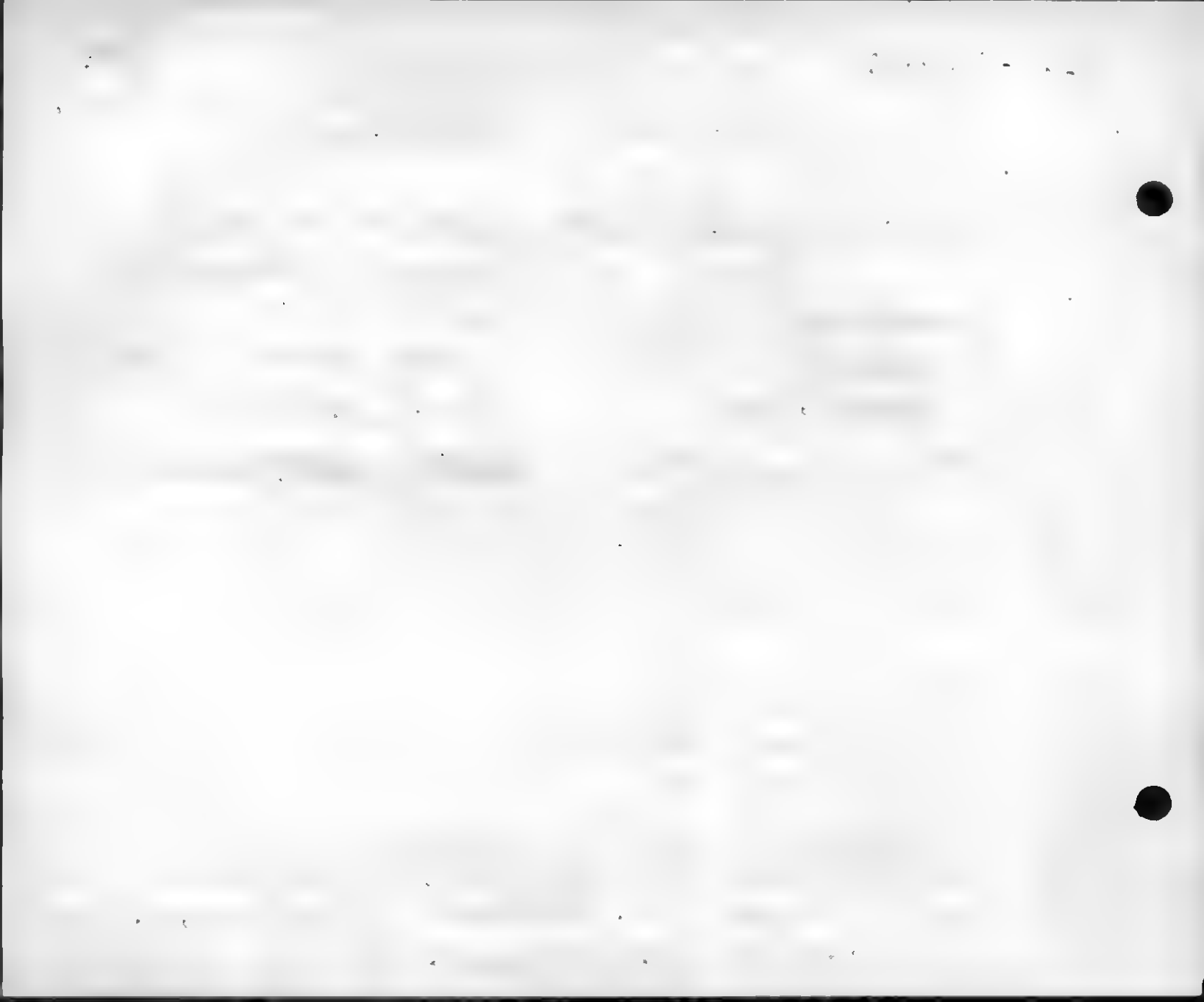
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06413

CERTIFICATE OF DEATH

06408

| | | | | | | | |
|---|----------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Baltimore</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)
<u>Baltimore</u> | | c. LENGTH OF STAY IN 1b
<u>11 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Baltimore County General Hosp.</u> | | | | d. STREET ADDRESS
<u>3409 Kimbark Rd.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Kate L. Snyder</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>11</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>8/4/80</u> | 9. AGE (In years last birthday) <u>86</u> yrs | IF UNDER 1 YEAR
Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. | | IF UNDER 24 HRS
Hours <u>11</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>America</u> | |
| 13. FATHER'S NAME
<u>Leibel, Louis</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Sord McKinis</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO
<u>None</u> | | 17. INFORMANT
<u>Correll Snyder</u> Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>La 7 pancreas</u>
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | |
| 20c. TIME OF INJURY Month, Day Year
Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5-11-1967</u> to <u>5-11-1967</u> ; that (I) (we) last saw the deceased alive on <u>5-11-1967</u> , and that death occurred at <u>9:45</u> M, from causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE
<u>[Signature]</u> | | | | M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<u>5-11-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Dr. Lai</u> | | | | 22d. ADDRESS
<u>B.C. G. Hospital</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>5/13/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Olive Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Randallstown, Md. 21133</u> | |
| 24. FUNERAL DIRECTOR
<u>Loring Byers-8728 Liberty Rd. Randallstown, Md.</u> | | | | 25a. REC'D BY REGISTRAR
<u>[Signature]</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

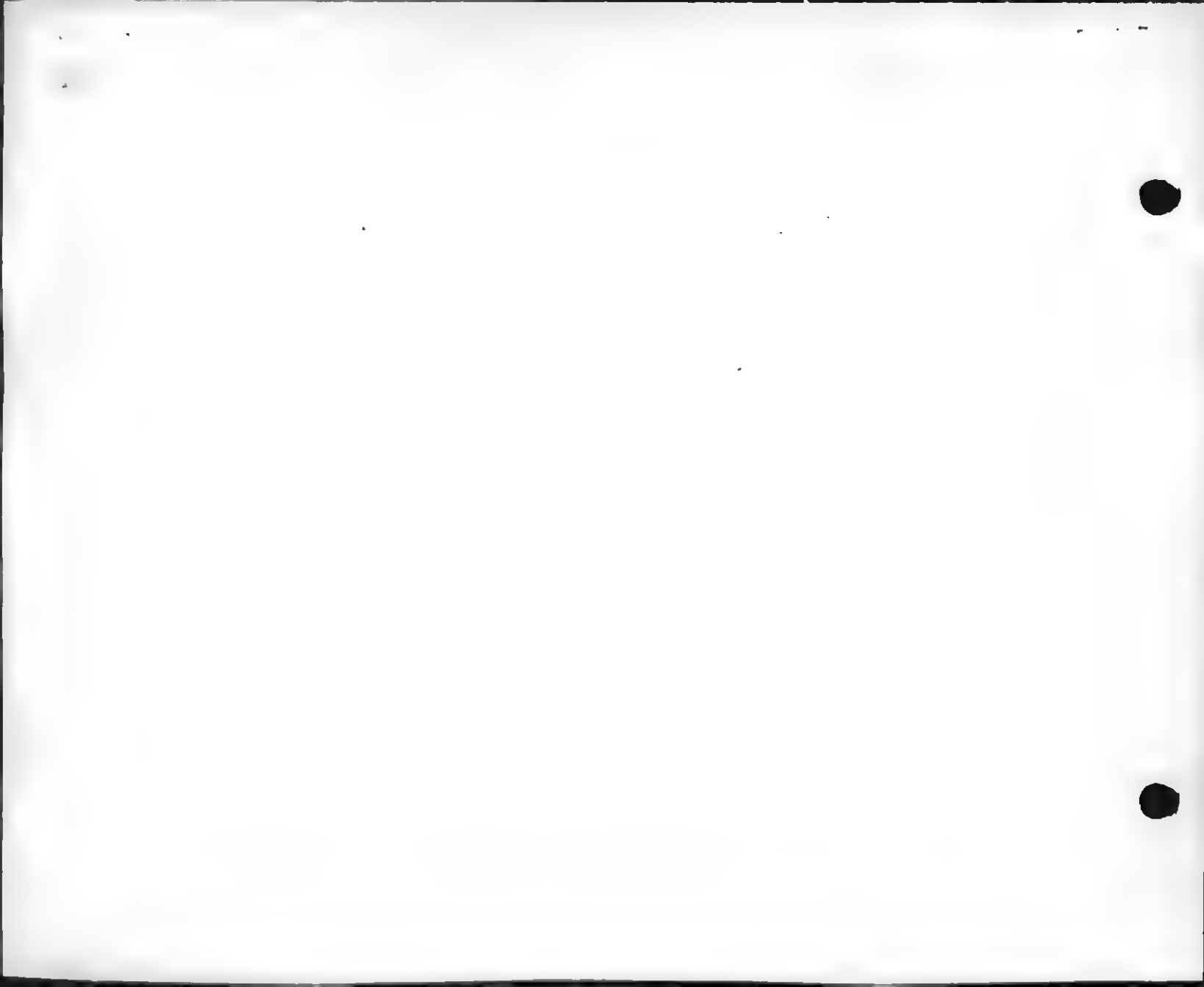


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--------------------------|--|---|--|---|--|---|---|--|--|
| <div> <div>06420</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>1967</div> </div> | | | | | | | | | | | |
| 1 PLACE OF DEATH
a COUNTY BALTIMORE MARYLAND | | | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE MD. b. COUNTY BALTO | | | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE 12 | | | | c LENGTH OF STAY IN 1b | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE 03 | | | | | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1013 ST. ALBANS RD | | | | | | d. STREET ADDRESS
1013 ST. ALBANS RD | | | | e IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) THOMAS WALTER SOMMER First Middle Last | | | | | | 4 DATE OF DEATH MAY 27 1967 Month Day Year | | | | | |
| 5 SEX M | | 6 COLOR OR RACE W | | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> D VORCED <input type="checkbox"/> | | 8 DATE OF BIRTH OCT. 23, 1881 | | 9 AGE (In years last birthday) 85 yrs | | F UNDER 1 YEAR Months Days | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CONCRETE FINISHER | | | | 10b KIND OF BUSINESS OR INDUSTRY
CONCRETE IND. | | 11 BIRTHPLACE (State or foreign country)
MARYLAND | | | 12 CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13 FATHER'S NAME JOHN BARTINE J. BATINE SOMMER | | | | | | 14 MOTHER'S MAIDEN NAME MAGGIE A. HERBST | | | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service) NONE | | | | 16 SOC. A. SECURITY NO. 216-18-0257 | | 17 INFORMANT Address | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
H X C I DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) | | 20f (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE William A. Pillsbury M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22. DATE SIGNED | | |
| EXAMINER'S NAME (Type) William A. Pillsbury | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER John Dunn M.D. | | |
| 23a BURIAL CREMATION, REMOVAL (Specify) | | | | | | 23b DATE THEREOF MAY 31, 1967 | | 23c NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY | | 23d LOCATION (City or Town) (County) (State) BALTIMORE, MD. | |
| 24 FUNERAL DIRECTOR John Dunn's Sons, Towson, Md. ADDRESS | | | | | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | DATE JUN 5 1967 Charles Judge | |



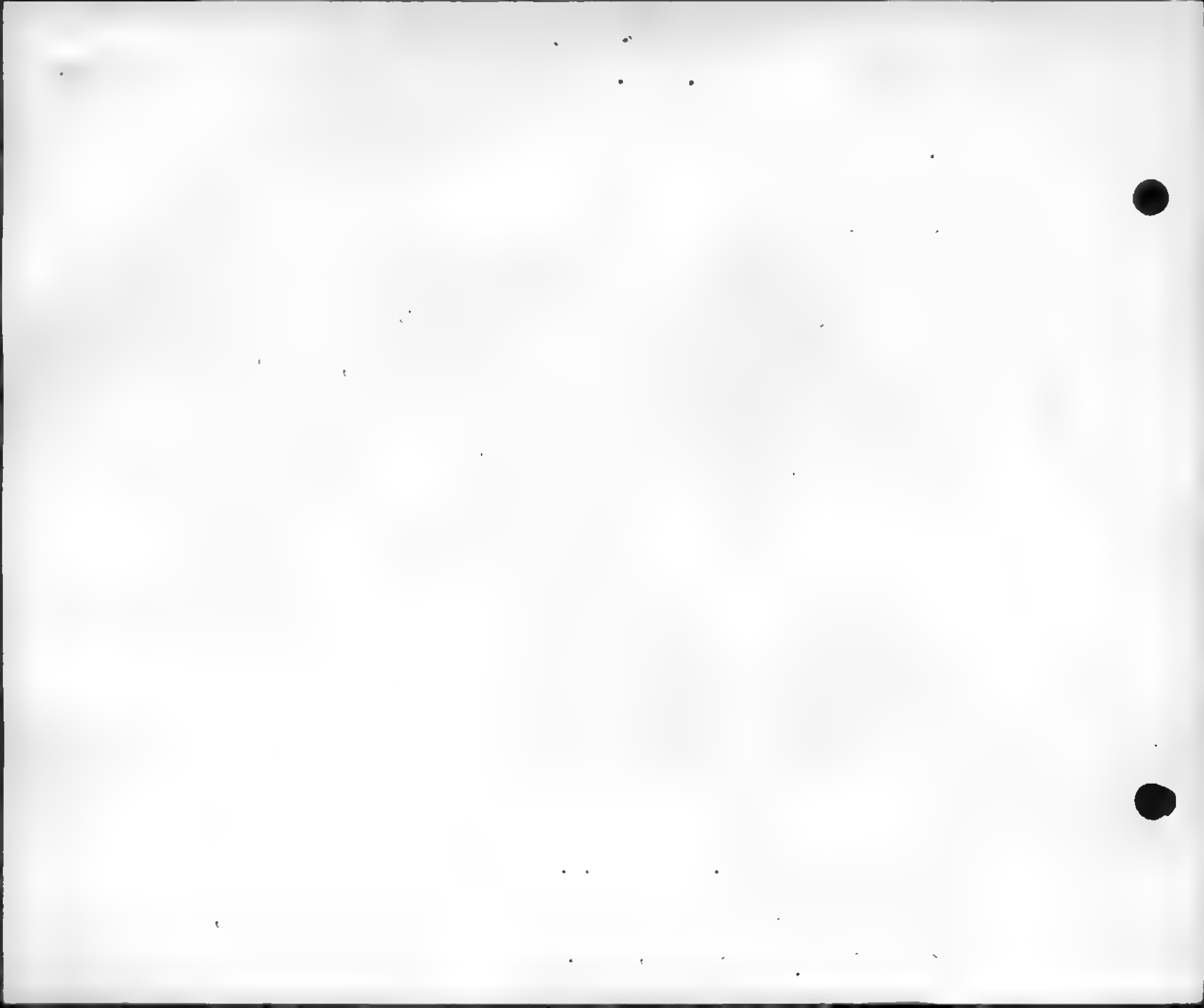
FOR STATE
HEALTH DEPT.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1 PLACE OF DEATH
a COUNTY
Baltimore
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
c LENGTH OF STAY IN b
Baltimore
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph's Hospital | | 2 USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission)
a STATE
Maryland
b COUNTY
Baltimore
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)
Baltimore
d STREET ADDRESS
1419 Limit Avenue 21212
e IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED
(Type or print)
DARCY
First Middle Last
SPICKA | | 4 DATE OF DEATH
Month Day Year
5 23 19 67 | |
| 5 SEX
Female | 6 COLOR OR RACE
White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
May 16, 1967 |
| 9 AGE (In years last birthday)
yrs | | 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | 10b KIND OF BUSINESS OR INDUSTRY
Baltimore, Maryland |
| 11 BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12 CITIZEN OF WHAT COUNTRY?
None | |
| 13 FATHER'S NAME
Richard Spicka | | 14 MOTHER'S MAIDEN NAME
Janice Hall | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16 SOCIAL SECURITY NO.
None | 17 INFORMANT
Address
Richard Spicka Same |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Interstitial pneumonia / (SDIT) /
7541 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Congestive heart failure
DUE TO (c) Patent ductus arteriosus | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Interstitial pneumonia | | | 19 WA. AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
RUSSELL S. FISHER, M.D.
EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MED. CA. EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county) | |
| 22. DATE SIGNED
5-24-67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
| Burial | 5-24-67 | New Cathedral | Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
Mitchell-Wiedefeld Home, Inc.
6500 York Rd. 21212 | | 25a. REC'D BY REGISTRAR
MAY 25 1967
25b. REGISTRAR'S SIGNATURE
f Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|---|--|---|-------------------------|---|--|-------------------------------------|---|---|--|
| 26422 Item #16 Film 5/10/67 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | | c. LENGTH OF STAY IN ID | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Greater Baltimore Medical Center</u> | | | | | d. STREET ADDRESS
<u>1557 Cottage Lane</u> | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>MARY</u> Middle <u>IRENE</u> Last <u>SPONSER</u> | | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>4</u> Year <u>1967</u> | | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>09-23-99</u> | | 9. AGE (In years last birthday)
<u>67</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Baltimore, Md.</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | |
| 13. FATHER'S NAME
<u>J Oscar Hulse</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Dixon, Rena</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>unknown</u> | | 17. INFORMANT
Address
<u>Mrs. Doris Naumann same address</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Massive pulmonary embolization</u>
DUE TO (b) <u>Left femoral vein thrombosis</u>
DUE TO (c) <u>Carcinomatosis - endometrial carcinoma</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>15 min.</u>
<u>2 days</u>
<u>14 mos.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that (if this hospital) attended the deceased from <u>February</u> , 19 <u>66</u> , to <u>May 4</u> , 19 <u>67</u> , that (if we) last saw the deceased alive on <u>May 4</u> , 19 <u>67</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>Reinhold O. Goehl, Jr.</u> | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<u>May 4, 1967</u> | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>R.O. GOEHL, JR., M.D.</u> | | | | | 22d. ADDRESS
<u>6701 N. CHARLES ST., BALTO. MD 21204</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>5/8/1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Baltimore National Cem.</u> | | | 23d. LOCATION (City, town or county) (State)
<u>Baltimore, Md.</u> | | |
| 24. FUNERAL DIRECTOR
<u>Wm J. Tabor & Sons</u> | | | | | 25a. REC'D BY REGISTRAR
<u>Wm J. Tabor</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06423

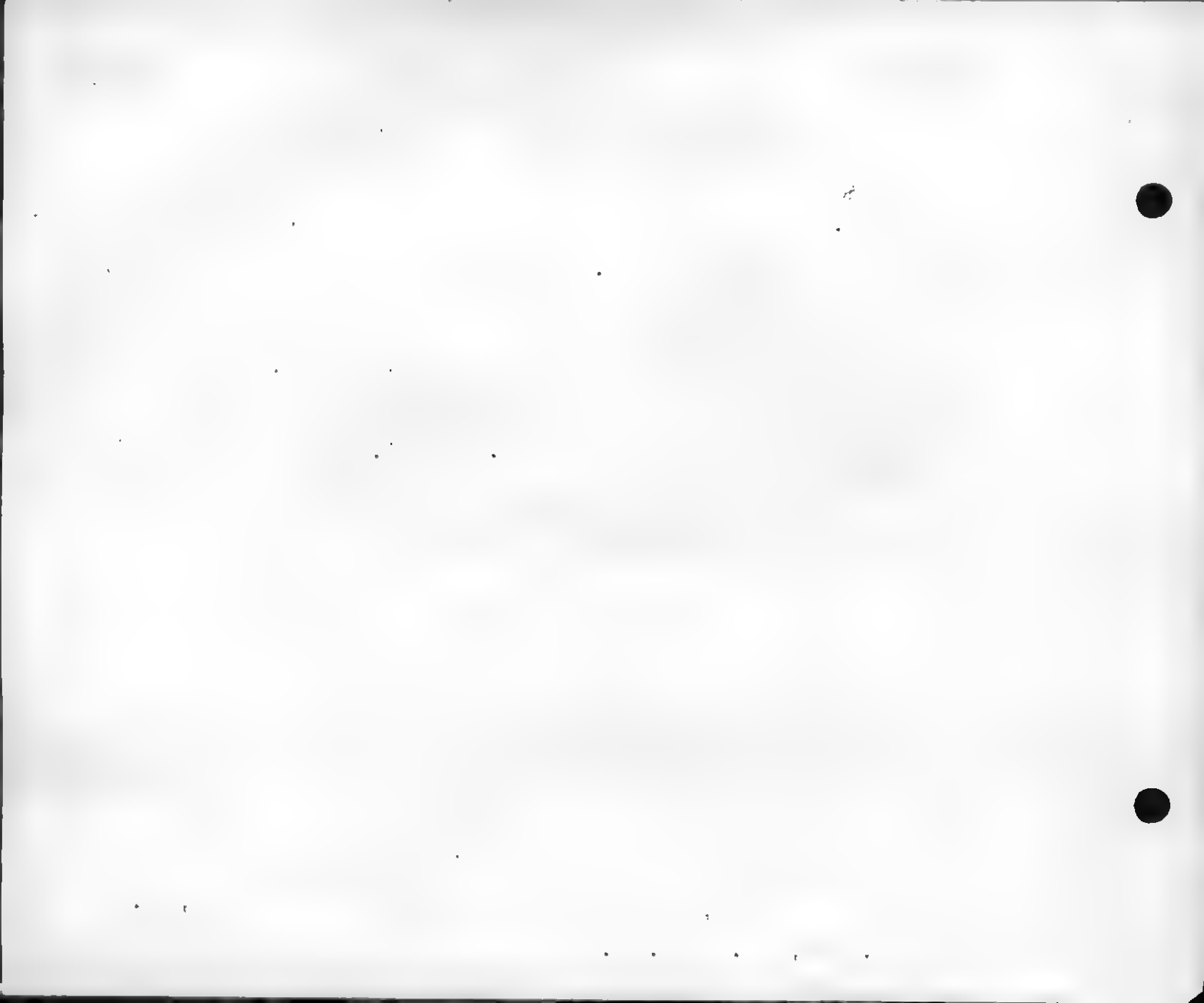
CERTIFICATE OF DEATH

06112

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b
Baltimore 21206 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | d. STREET ADDRESS 6108 Fairdel Avenue | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
Caryn A. Stamm | | 4. DATE OF DEATH Month Day Year
May 5 19 67 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-28-67 |
| 9. AGE (In years last birthday) yrs 2 | | 10. IF UNDER 1 YEAR Months Days Hours Min. 5 19 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md. | |
| 11. BIRTHPLACE (County & State, or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Edward Conrad Stamm | | 14. MOTHER'S MAIDEN NAME Jean Amato | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mr. Edward C. Stamm | | Address (Same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Aspiration pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Bacteremia
DUE TO
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that 20 (this hospital) attended the deceased from April 5 19 67 to May 5 19 67 that 1 (we) last saw the deceased alive on May 5 19 67 , and that death occurred on 5:10 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE M. Chang | | 22b. DATE SIGNED May 5, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Myung Y. Chang, M.D. | | 22d. ADDRESS 7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 5/6/67. | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | 25a. REC'D BY REGISTRAR 5 1967 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06424

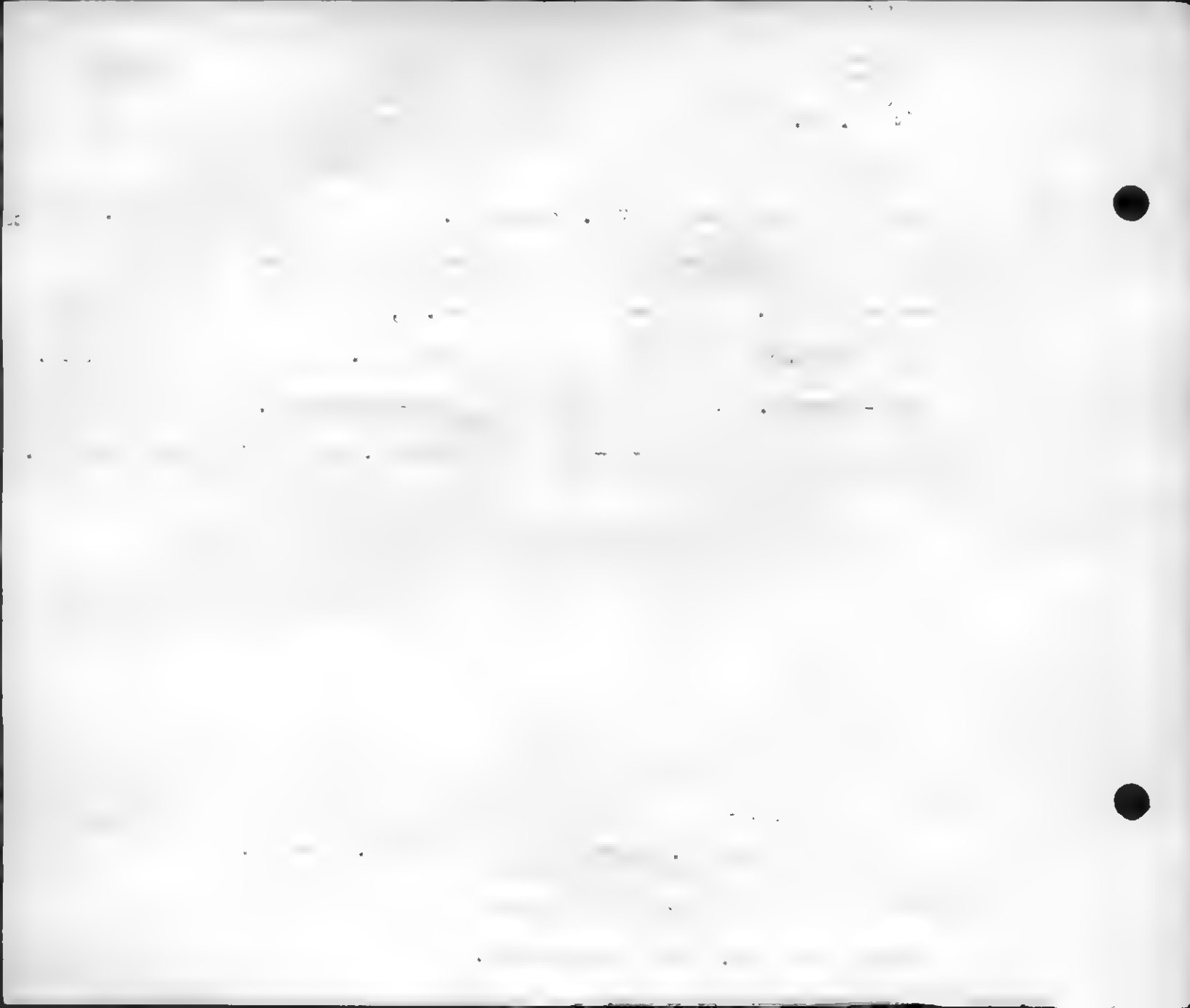
CERTIFICATE OF DEATH

06413

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Balto. Md.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore | |
| c. LENGTH OF STAY IN TB | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Shady Noek Nursing Home 1002 N. Relling | | d. STREET ADDRESS
512 Charring Cross Rd. | |
| 3. NAME OF DECEASED
(Type or print)
Margaret Staup | | 4. DATE OF DEATH
May 3, 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
Cauc. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 5, 1902 |
| 9. AGE (In years last birthday)
64 | | 10. IF UNDER 1 YEAR
Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerical Work | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State or foreign country)
Balto. Co. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
late- James C. Ball | | 14. MOTHER'S MAIDEN NAME
late- Margaret A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO
218-36-6755 | |
| 17. INFORMANT
Miss Mary A. Ball | | Address
512 Charing Cross Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis
DUE TO (b) Carcinoma of the breast
DUE TO (c) 170X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
2 months |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Jan , 19 60 , to May 3 , 1967, that (I) (we) last saw the deceased alive on April 30, 1967 , and that death occurred at 5:15 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Martin L. Singewald | | 22b. DATE SIGNED
5/4/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Martin L. Singewald | | 22d. ADDRESS
11 E. Chase St. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
May 6, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | 23d. LOCATION (City or Town) (County) (State)
Baltimore Maryland |
| 24. FUNERAL DIRECTOR
Witzke Funeral Dir. 4101 Edmondson Ave. | | 25a. REC'D BY REGISTRAR
DATE MAY 8 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
James G. Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
5M 1/65

06426

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6-14

| | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sparrows Point | | c. LENGTH OF STAY IN 1b
MAYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | d. STREET ADDRESS
948 Woodlyn Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Raymond | | Middle
S. | | Last
STEELEY | | 4. DATE OF DEATH
Month 5 Day 19 Year 67 | | 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
5-11-16 | | 9. AGE (In years last birthday)
51 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Steel Worker | | 10b. KIND OF BUSINESS OR INDUSTRY
Steel Making | | 11. BIRTHPLACE (State or foreign country)
PENNA. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
RAYMOND STEELEY | |
| 14. MOTHER'S MAIDEN NAME
JENNIE HORN | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WWII | | 16. SOCIAL SECURITY NO.
079-14-6302 | | 17. INFORMANT
MARGARET STEELEY | | Address
A BOVE | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
N | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
N E | | 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED
5-19-67 | | ACTUAL SIGNATURE
Melvin B. Davis, M.D. | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type)
Melvin B. Davis, M.D. | | 6800 Morningside Road
Dundalk, Md. | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/22/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION (City, town or county) (State)
Baltimore, Md. | | 24. FUNERAL DIRECTOR
J.H. Connelly Inc. | |
| ADDRESS
300 Main | | 25a. REC'D BY REGISTRAR
DATE MAY 23 1967 | | 25b. REGISTRAR'S SIGNATURE
John F. Judge | | | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06425

CERTIFICATE OF DEATH

00115

| | | | |
|---|----------------------------------|--|-----------------------------------|
| 1 PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY -- | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills | | c. LENGTH OF STAY IN 1b
3 yrs. | |
| c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Rosewood State Hospital | | d. STREET ADDRESS
915 Stiles Street | |
| 3 NAME OF DECEASED
(Type or print)
First Suzanne Middle Paulette Last STEIN | | 4. DATE OF DEATH
Month 5 Day 21 Year 19 67 | |
| 5 SEX
Female | 6 CO. OR OR RACE
White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
1-24-63 |
| 9 AGE (In years lost birthday) 4 yrs. | | IF UNDER 1 YEAR
Months 4 Days 21 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dependent | | 10b. KIND OF BUSINESS OR INDUSTRY
none | |
| 11 BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12 CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13 FATHER'S NAME
Harry John Stein | | 14. MOTHER'S MAIDEN NAME
Eleanor Mary Cucco | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no -- | | 16. SOCIAL SECURITY NO
none | |
| 17. INFORMANT
Rosewood Records, Owings Mills, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Aspiration Pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Microcephaly Congenital
DUE TO
(c) | | INTERVAL BETWEEN ONSET OF DEATH
48 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19 WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year
Hour 19 o.m.
p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (this hospital) attended the deceased from May 4, 1964 to May 21, 1967 , that (we) lost the deceased alive on May 21, 1967 , and that death occurred at 8:25 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Richard A. Jones | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Richard A. Jones | | 22d. ADDRESS
Rosewood State Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
5-22-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
HOLY ROSARY CEM. | | 23d. LOCATION (City or Town) (County) (State)
BALTO. Co. MD. | |
| 24 FUNERAL DIRECTOR
Wm Fialkowski | | 25. REC'D BY REGISTRAR
MAY 24 1967 | |
| 26. ADDRESS
2007 EASTERN AVE. | | 26b. REGISTRAR'S SIGNATURE
J. Jones | |
| 26c. CITY, COUNTY, STATE
BALTO MD 21231 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Handwritten text, possibly a signature or name, appearing in the center of the page.

Handwritten text, possibly a signature or name, appearing at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

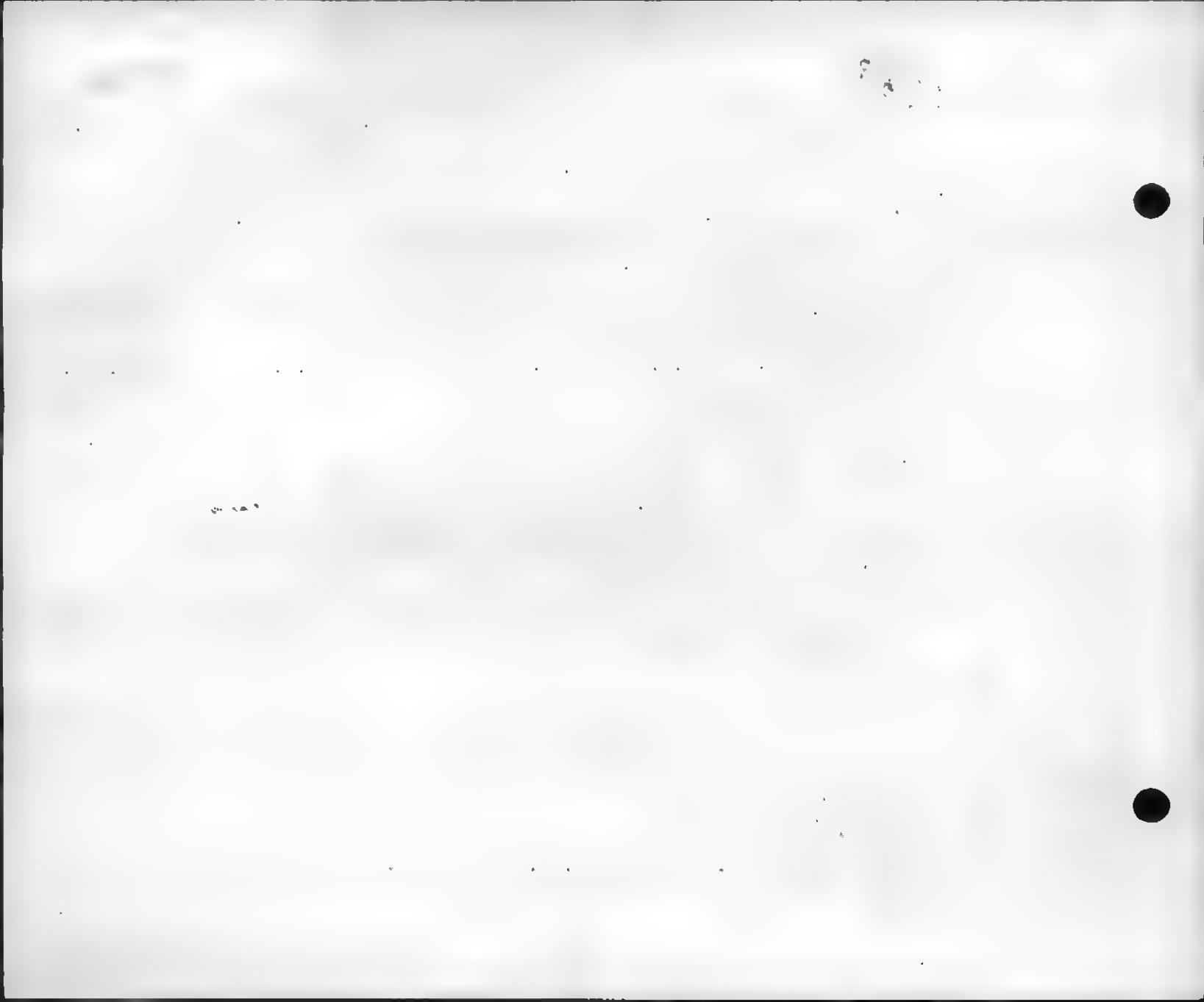
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06428

CERTIFICATE OF DEATH

09216

| | | | |
|--|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)
a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lutherville | | c. LENGTH OF STAY in lb
25 yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
124 Greenridge Rd. | | e. STREET ADDRESS
124 Greenridge Rd. | |
| 3. NAME OF DECEASED (Type or print)
Carl First Middle Last A. Stoutenburg | | 4. DATE OF DEATH
Month May Day 1 Year 1967 | |
| 5. SEX
M | 6. COLOR OR RACE
W. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-24-1903 |
| 9. AGE (In years last birthday)
63 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
District Mgr. | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Slicing M. Co | |
| 11. BIRTHPLACE (County & State, or foreign country)
Bloomville, N.Y. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George Stoutenburg | | 14. MOTHER'S MAIDEN NAME
Emma Messick | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
Yes, 1919-1922 | | 16. SOCIAL SECURITY NO.
070 03 8659 | |
| 17. INFORMANT
Mable Stoutenburg | | 18. ADDRESS
124 Greenridge R. Lutherville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)
DUE TO CORONARY OCCLUSION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE
(c) | | INTERVAL BETWEEN ONSET AND DEATH
10 MIN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)
DIABETES MELLITUS | | 19. WAS AUTOPSY PERFORMED? #
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from APR 23 , 1967, to MAY 1 , 1967, that (I) (we) last saw the deceased alive on APR 23 , 1967, and that death occurred at 8:50 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
T. C. Siwinski | | 22b. DATE SIGNED
May 2, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Thaddeus C. Siwinski, M. D. | | 22d. ADDRESS
206 W. Pennsylvania Avenue (21204) | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE THEREOF
May 5, 67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley | | 23d. LOCATION (City or Town) (County) (State)
Cockeysville, Balto, Md. | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, Towson, Md. 21204 | | 25a. REC'D BY REGISTRAR
MAY 5 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06427

CERTIFICATE OF DEATH

06117

| | | | |
|--|--|---|---|
| 1 PLACE OF DEATH
a COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion)
a STATE <u>Maryland</u> b COUNTY <u></u> | |
| b CITY OR TOWN (If outside corporate lmts, write RURAL and give nearest town)
<u>Randallstown</u> | | c LENGTH OF STAY IN 1b
<u>Baltimore</u> | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Balto. Co. General Hospital</u> | | e STREET ADDRESS
<u>3703 Copley Rd.</u> | |
| 3 NAME OF DECEASED
(Type or print)
First <u>Bernice</u> Middle <u>L.</u> Last <u>Street</u> | | 4 DATE OF DEATH
Month <u>5</u> Day <u>10</u> Year <u>1967</u> | |
| 5 SEX
<u>F</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11-10-1914</u> |
| 9. AGE (In years last birthday)
<u>52</u> yrs | | 10. IF UNDER 1 YEAR
Months <u></u> Days <u></u> hours <u></u> Min. <u></u> | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Social Security</u> | |
| 11 BIRTHPLACE (County & State, or foreign country)
<u>Balto, Maryland</u> | | 12 CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13 FATHER'S NAME
<u>Samuel G. Criss</u> | | 14 MOTHER'S MAIDEN NAME
<u>Martha L. Criss</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16 SOCIAL SECURITY NO
<u>219-28-5223</u> | |
| 17 INFORMANT
<u>Mr. Harold Street</u> | | Address
<u>3703 Copley Rd.</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u>
DUE TO (b) <u></u>
DUE TO (c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
<u>months</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u></u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>66</u> , to <u>May 10</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>May 10</u> , 19 <u>67</u> , and that death occurred at <u>2:00</u> P.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>David L. Miller</u> M.D. | | 22b. DATE SIGNED
<u>May 10-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>David L. Miller</u> | | 22d. ADDRESS
<u>Lincoln Rd Owings Mills Md.</u> | |
| 23a. BURIAL CREMATION REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>5-13-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Arbutus Mem. Park</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Arbutus Md.</u> |
| 24 FUNERAL DIRECTOR
<u>Morton & Dyett Fitt</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Juerg</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Juerg</u> | | DATE
<u>MAY 12 1967</u> | |



HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

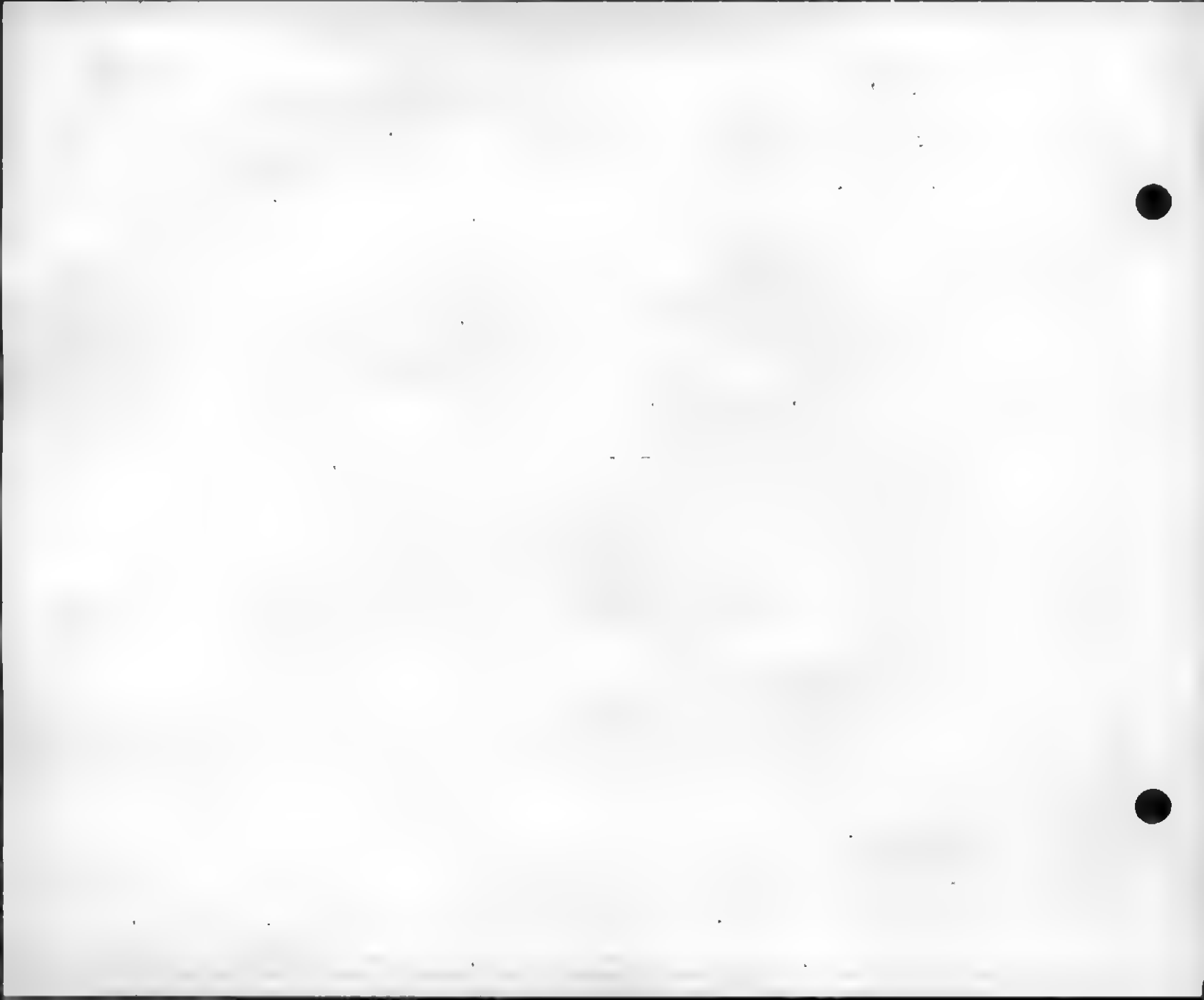
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06423

| | | | |
|--|---------------------------------|--|---|
| 1 PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE <u>Md.</u> b COUNTY <u>Baltimore</u> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Stoneleigh</u> | | c LENGTH OF STAY IN 1b
<u>Stoneleigh</u> <u>Baltimore 21212</u> | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>6207 Beechwood Road</u> | | d STREET ADDRESS
<u>6207 Beechwood Road</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Susanna</u> First <u>M</u> Middle <u>Striebel</u> Last | | 4 DATE OF DEATH
Month <u>May</u> Day <u>4</u> Year <u>1967</u> | |
| 5. SEX
<u>female</u> | 6 COLOR OR RACE
<u>white</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
<u>Nov. 30, 1877</u> |
| 9 AGE (In years last birthday) <u>89</u> yrs | | 10 IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u> </u> | |
| 11 BIRTHPLACE (County & State, or foreign country)
<u>Germany</u> | | 12 COUNTRY OF WHAT COUNTRY?
<u>USA</u> | |
| 13 FATHER'S NAME
<u>Lorenz Schiller</u> | | 14. MOTHER'S MAIDEN NAME
<u>Margaret Wehrwein</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>216-01-4166</u> | |
| 17. INFORMANT
<u>Mrs Gretchen M. Harrison</u> | | Address
<u>same</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Wound of Infanticide</u>
DUE TO (b) <u> </u>
DUE TO (c) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u> </u>
(c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u> </u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u> </u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>9</u> a.m. <u> </u> p.m. <u> </u> 19 <u>67</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> |
| 20f. (City or town)
<u> </u> | | (County) <u> </u> (State) <u> </u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5-4</u> , 19 <u>67</u> , to <u>5-4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-4</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>W. M. Smith</u> | | 22b. DATE SIGNED
<u>5-5-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>W. M. Smith</u> | | 22d. ADDRESS
<u>630-5 THE ALAMEDA</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | | 23b. DATE THEREOF
<u>5/8/67.</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Parkwood Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Leonard J. Ruck, Inc Baltimore, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 8 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles J. J...</u> | | | |



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VR A15 (4)
20 M 1/66

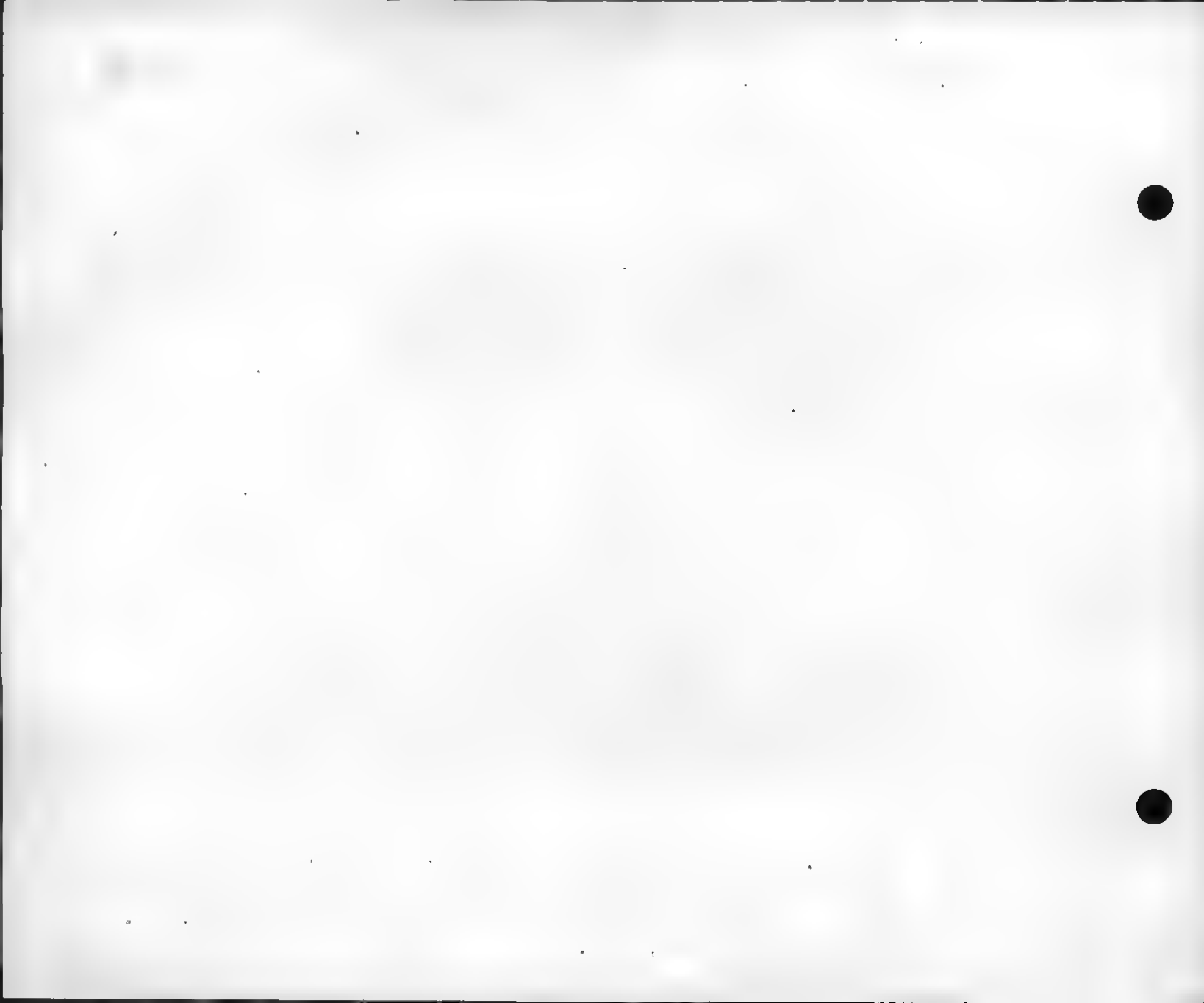
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06430

CERTIFICATE OF DEATH

06419

| | | | |
|---|---|--|--|
| 1 PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Md. b. COUNTY West | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rosedale | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1817 Ellinwood Road | | e. STREET ADDRESS
1817 Ellinwood Road | |
| 3 NAME OF DECEASED (Type or print)
MILDRED JOSEPHINE STUPRICH | | 4 DATE OF DEATH
Month 5 Day 7 Year 1967 | |
| 5 SEX
female | 6 COLOR OR RACE
white | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
4/19/15 |
| 9 AGE (In years last birthday) 52 yrs | | 10 IF UNDER 1 YEAR
Months 19 Days 19 Hours 19 Min 19 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)
Waitress | | 10b. KIND OF BUSINESS OR INDUSTRY
Holland House | |
| 11 BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | 12 CITIZEN OF WHAT COUNTRY? | |
| 13 FATHER'S NAME
Frank Kougl | | 14. MOTHER'S MAIDEN NAME
unknown | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
217-26-7383 | | 16 SOCIAL SECURITY NO
217-26-7383 | |
| 17 INFORMANT
Oscar Stuprich, 1817 Ellinwood Rd. | | Address 21206 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO (b) Metastatic Carcinoma of the breast / lungs
DUE TO (c) Lungs & liver | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21 I certify that (I) (this hospital) attended the deceased from June 1964 to April 20 1967 , that (I) (we) last saw the deceased alive on April 20 1967 , and that death occurred at 10 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. John Geldrich | | 22b. DATE SIGNED
May 9/1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. John Geldrich | | 22d. ADDRESS
8019 Philadelphia Road | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
5/11/67 | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cem | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. |
| 24. FUNERAL DIRECTOR
Schimmunek Funeral Home, Inc.
3331 Brehms Lane | | 25a. REC'D BY REGISTRAR
MAY 11 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

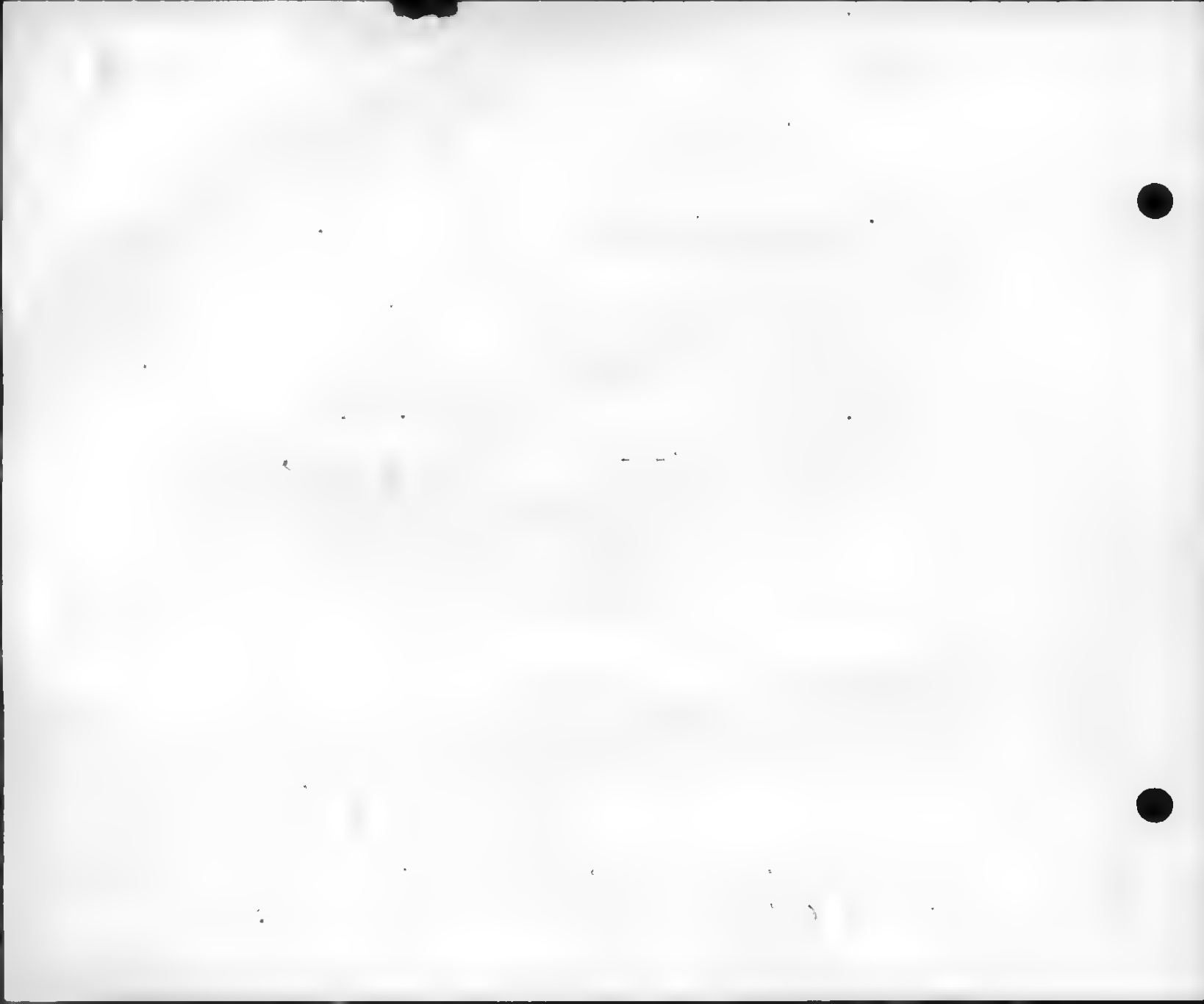
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06431

CERTIFICATE OF DEATH

06420

| | | | | | | | |
|---|----------------------------------|---|-------------------------------------|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland
b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Josephs Hospital | | | | d. STREET ADDRESS
1912 E. Madison Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Emma Middle M Last SUPIK | | 4. DATE OF DEATH
Month May Day 28 Year 1967 | | | | | |
| 5. SEX
Female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-22-08 | 9. AGE (In years last birthday)
58 yrs. | 10. IF UNDER 1 YEAR
Months Days Hours Min | | 11. IF UNDER 24 HRS.
Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
Social Security Agency | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles A. Supik | | | | 14. MOTHER'S MAIDEN NAME
Emma H. Kozlovsky | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) no (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
215-10-8473 | | 17. INFORMANT
Edward Supik, brother, Box 67 Route 1, Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute hemorrhagic pancreatitis.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that M (this hospital) attended the deceased from May 27 , 19 67 , to May 28 , 19 67 , that he (we) last saw the deceased alive on May 28 , 19 67 , and that death occurred at 7:10 P.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Juana S. Cockburn M.D. | | | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
May 29, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Juana S. Cockburn, M.D. | | | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
6/1/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Balto., Md. | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home
3331 Brehms Lane #13 | | | | 25a. REC'D BY REGISTRAR
JUN 1 1967 | | 25b. REGISTRAR'S SIGNATURE
J. J. [Signature] | |



CERTIFICATE OF DEATH

06432

06421

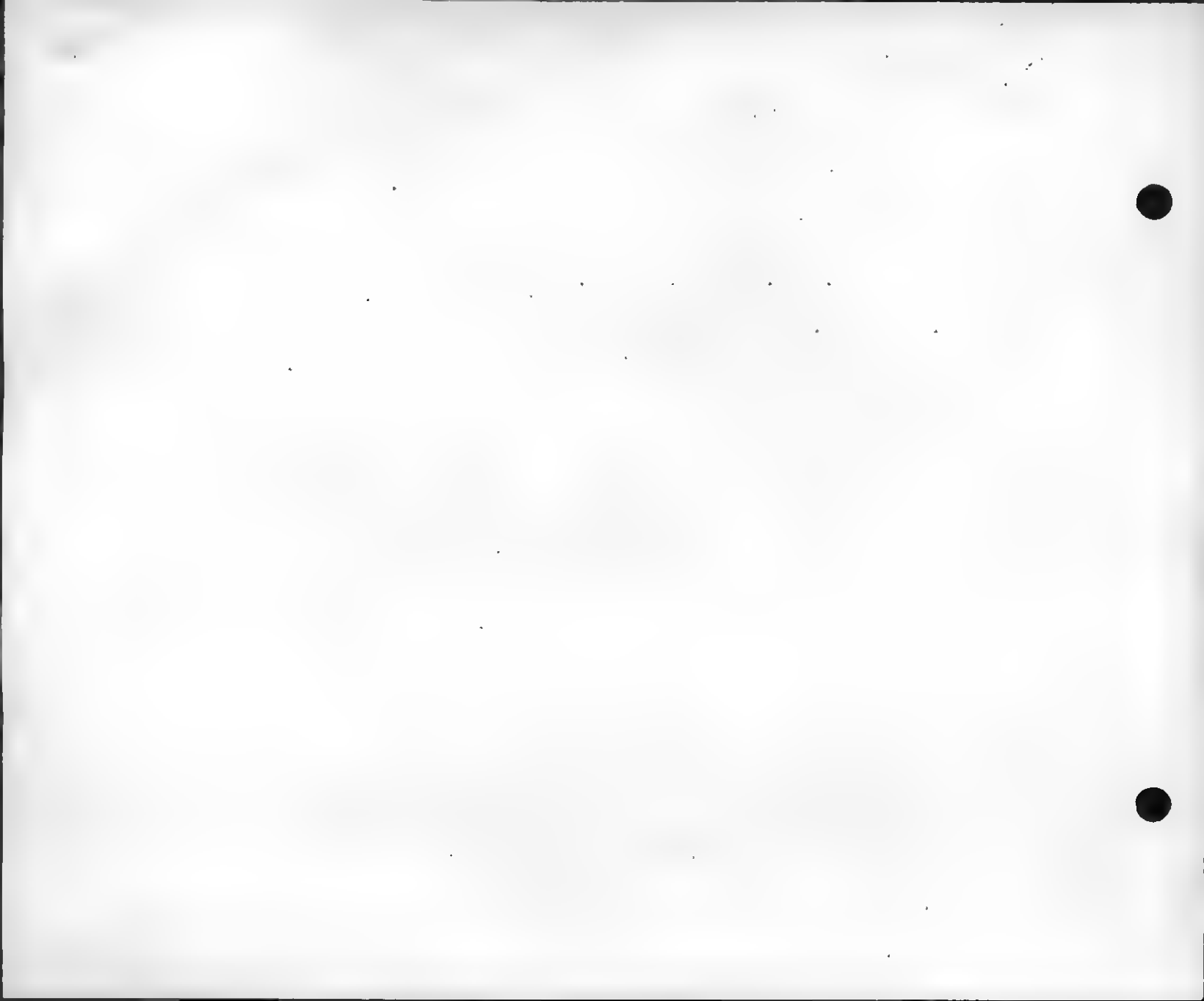
| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville
c. LENGTH OF STAY IN 1b 22 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8801 Harford Road St. Joseph's Hosp. | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. 21234 Parkville
d. STREET ADDRESS 8801 Harford Rd.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Rt. Rev. William J. Sweeney
SEX M. 6. COLOR OR RACE W. 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Priest
13. FATHER'S NAME Dennis Sweeney | | 4. DATE OF DEATH May 12 1967
5. B. DATE OF BIRTH March 5 1901 9. AGE (In years, last birthday) 66 yrs.
11. BIRTHPLACE (Country & State or foreign country) Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Family Records
17. INFORMANT Family Records | |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 Congestive heart failure
DUE TO (b) Chronic atherosclerotic Cardiovascular Disease
DUE TO (c) with Coronary artery Disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I(a) Old Myocardial Infarction | | INTERVAL BETWEEN ONSET AND DEATH 30-45 Min
15-20 yrs
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20c. TIME OF INJURY Month, Day, Year 19
Hour a.m. 19 p.m. 19
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above | | | |
| 22a. SIGNATURE Vicente P. Ang
22c. PHYSICIAN'S NAME (Type) VICENTE P. ANG | | 22b. DATE SIGNED May 13, 1967
22d. ADDRESS St. Joseph Hospital | |
| 23a. BURIAL, CREMATION, REBURY BURIAL
23b. DATE THEREOF 5-17-1967
23c. NAME OF CEMETERY OR CREMATORY New Cathedral
23d. LOCATION (City or town) (County) (State) Baltimore Md. | | 25a. REC'D BY REGISTRAR May 18 1967
25b. REGISTRAR'S SIGNATURE Charles Judge | |
| 24. FUNERAL DIRECTOR C. F. Evans & Son 8802 Harford Rd. | | | |

MEDICAL CERTIFICATION

Approved: Frank J. Sisk, Jr. MD 5/12/67 Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

665-9444



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

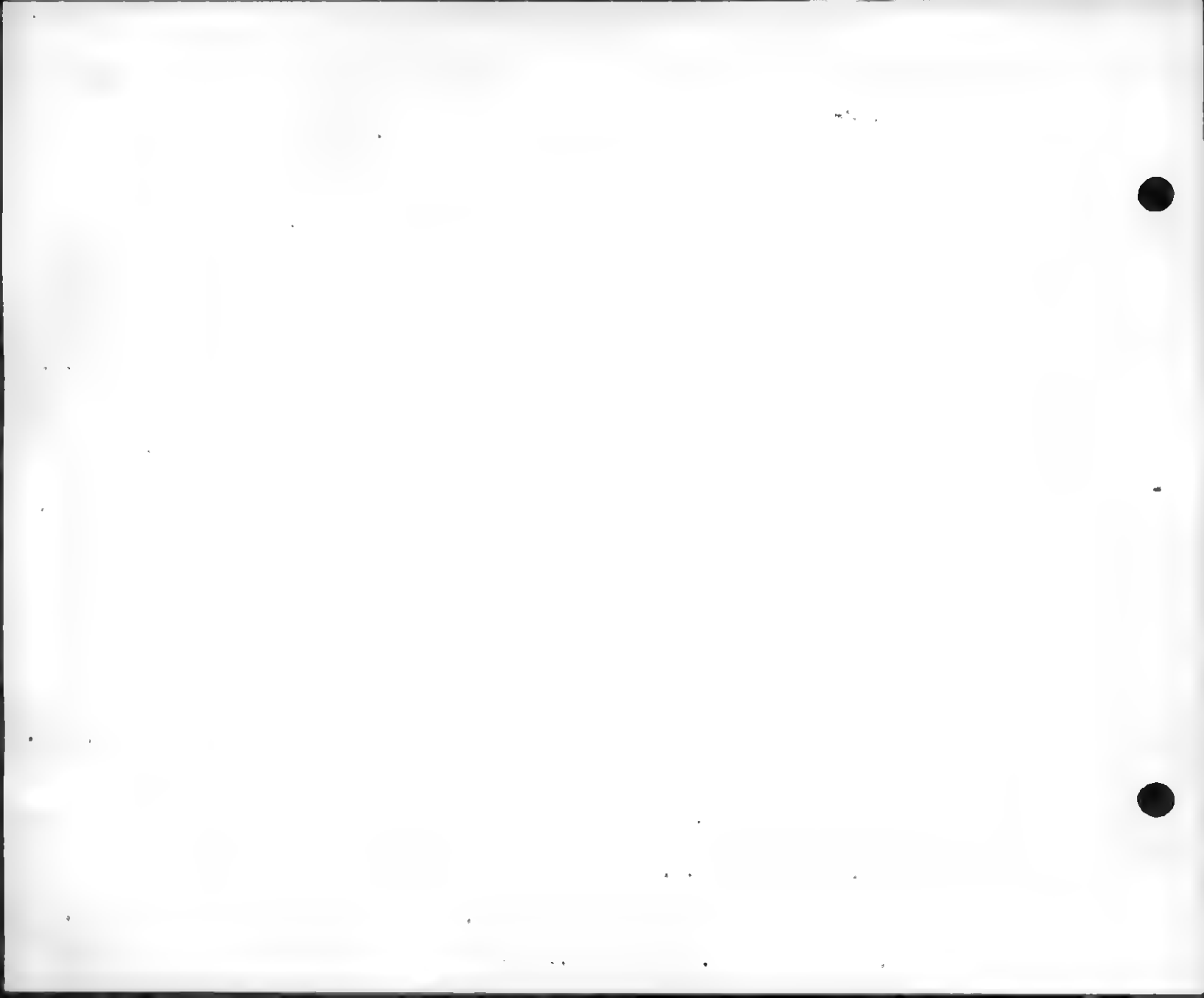
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36433

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5-22

| | | | |
|--|---------------------------------|--|--|
| 1 PLACE OF DEATH
a COUNTY <u>Balto.</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE <u>Md.</u> b COUNTY <u>Alleg.</u> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Owings Mills</u> | | c LENGTH OF STAY in 1b
<u>5 yrs.</u> | |
| c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland, Md.</u> | | | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Rosewood State Hosp.</u> | | d STREET ADDRESS
<u>12 Virginia Ave.</u> | |
| e RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3 NAME OF DECEASED
(Type or print) <u>LELAND EDWARD SWICK</u> | | 4 DATE OF DEATH
Month <u>5</u> Day <u>26</u> Year <u>19 67</u> | |
| 5 SEX <u>Male</u> | 6 COLOR OR RACE
<u>White</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
<u>1-11-55</u> |
| 9 AGE (In years last birthday)
<u>12</u> yrs | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS
Hours <u> </u> Min <u> </u> |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Dependent</u> | | 10b KIND OF BUSINESS OR INDUSTRY
<u>none</u> | |
| 11 BIRTHPLACE (State or foreign country)
<u>Allegany Co., Md.</u> | | 12 CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13 FATHER'S NAME
<u>Richard Lee Swick</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mildred Elizabeth Moss</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of serv.)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>none</u> | |
| 17. INFORMANT
<u>Rosewood Records, Owings Mills, Maryland</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Asphyxia due to aspiration of cookie</u>
DUE TO (b) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>25 min.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Severe Mental Retardation with hyperactivity</u> | | 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)
<u>Stuffed cookie in mouth and choked on cookie</u> | |
| 20c TIME OF INJURY Month, Day, Year
Hour <u>12:30</u> p.m. <u>5-26-1967</u> | | 20d INJURY OCCURRED
While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>
at work at work | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
<u>Holland Cottage, Rosewood St. Hosp.</u> | | 20f (City or town) (County) (State)
<u>Owings Mills, Balto., Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>D. D. Caples</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
<u>D. D. Caples, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22. DATE SIGNED
<u>5-26-67</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Address (Street, city, town, or county) | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b DATE THEREOF
<u>5/29/67</u> | |
| 23c NAME OF CEMETERY OR CREMATORY
<u>Sunset Memo. Pk.</u> | | 23d LOCATION (City or Town) (County) (State)
<u>Cumberland, Allegany, Md.</u> | |
| 24 FUNERAL DIRECTOR
<u>Philip B. Wendt 121 Mem. Ave., Cumb., Md.</u> | | 25a REC'D BY REG. STRAR
DATE <u>MAY 31 1967</u> | |
| 25b REGISTRAR'S SIGNATURE
<u>William A. Gude</u> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

96434

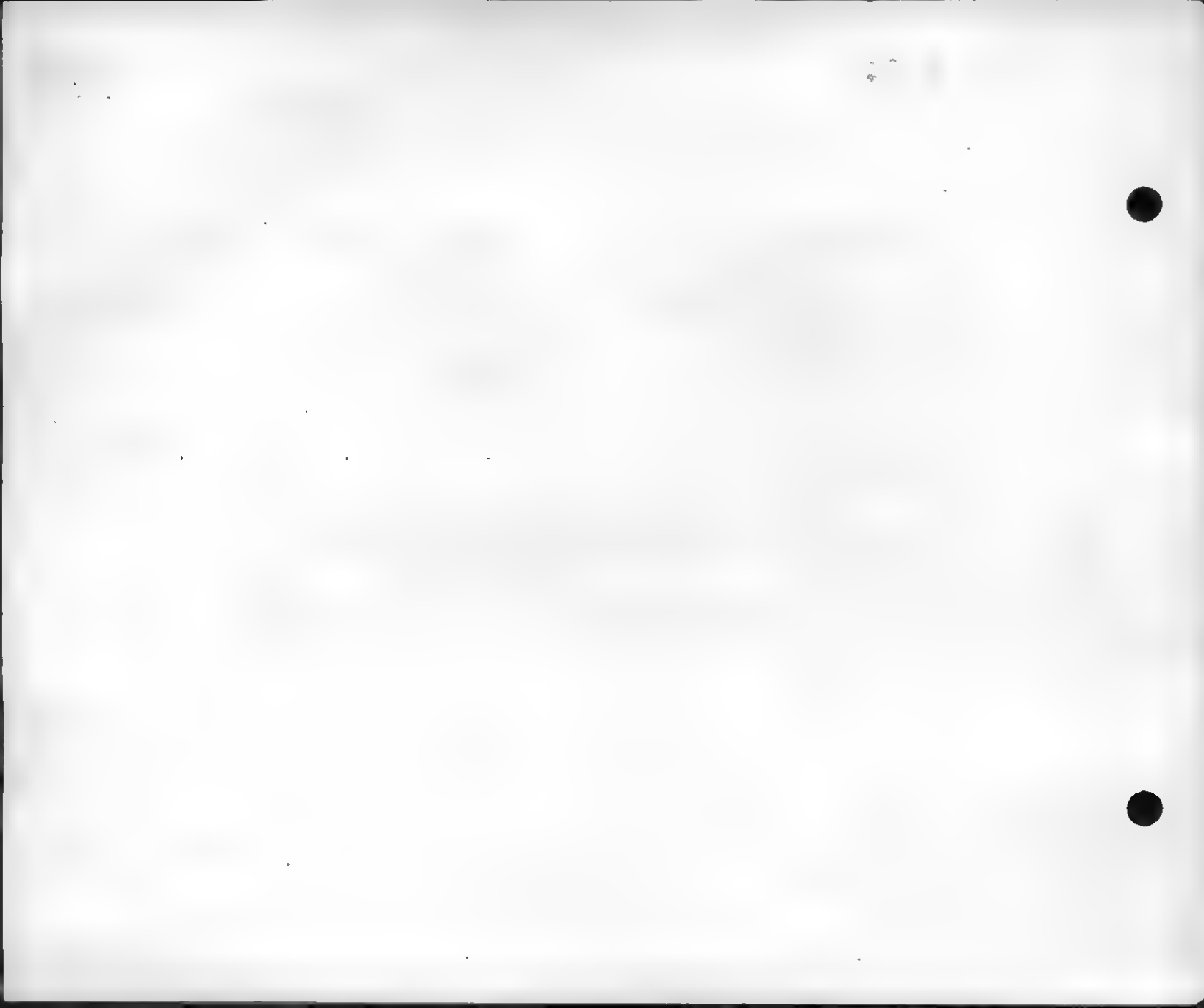
CERTIFICATE OF DEATH

96423

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Summit Nursing Home | | d. STREET ADDRESS
2683 West Park Drive 21207 | |
| 3. NAME OF DECEASED (Type or print)
First Blanche Middle Talbott Last | | 4. DATE OF DEATH
Month May Day 16 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/14/95 |
| 9. AGE (In years last birthday)
71 yrs | | 10. IF UNDER 1 YEAR
Months 16 Days 16 Hours 16 Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Row | | 14. MOTHER'S MAIDEN NAME
Susan | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
None | | 16. SOCIAL SECURITY NO
None | |
| 17. INFORMANT
Mrs. Florence A. Stump | | Address Lane 21229 710 N. Chapelgate | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive CARDIOVASCULAR Disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential Hypertension
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
At least 20 years
unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 pm | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from February 27, 1967 to MAY 16, 1967 , that (I) (we) last saw the deceased alive on MAY 14, 1967 , and that death occurred at 8:20 AM , from causes and on the date stated above | | | |
| 22a. SIGNATURE
Melvin N Borden | | 22b. DATE SIGNED
5/16/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Melvin Borden WI 5-6680 | | 22d. ADDRESS
5000 BALTO NATIONAL PIKE 21229 600 N. Chapel Gate Lane | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5/19/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Western Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard | | 25a. REC'D BY REGISTRAR
21229 4107 Wilkens Ave. | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | 25c. DATE
MAY 18 1967 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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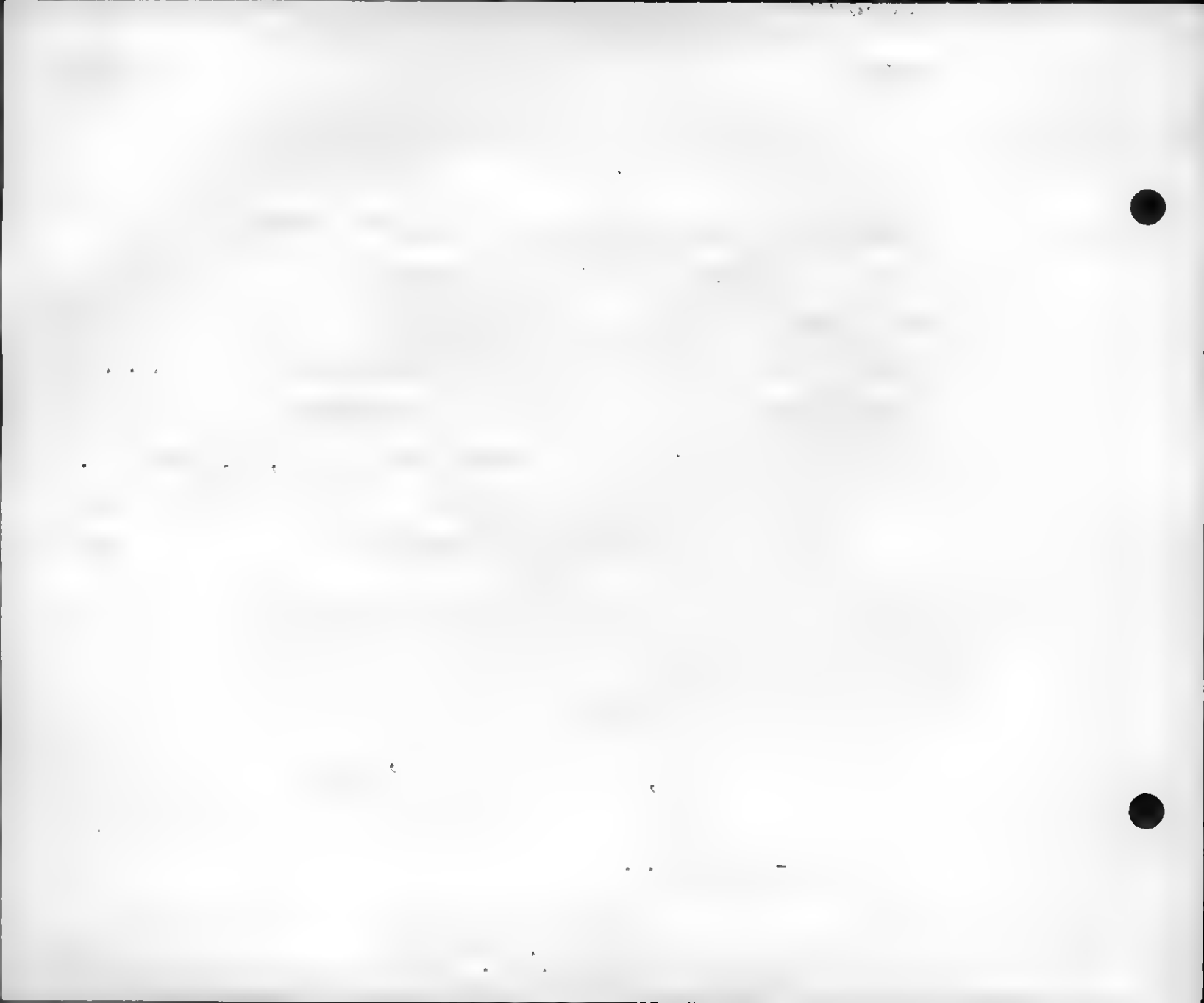
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06435

06424

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1 PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | | | c. LENGTH OF STAY IN TB
83 DAYS | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS
1313 WEST MULBERRY STREET | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3 NAME OF DECEASED (Type or print)
First WILLIAM Middle NMI Last TAILEY | | | | 4 DATE OF DEATH
Month MAY Day 27 Year 19 67 | | | |
| SEX
MALE | | 6 COLOR OR RACE
NEGRO | | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH
8/18/95 | |
| 9 AGE (In years last birthday)
71 yrs | | IF UNDER 1 YEAR
Months Days Hours Min | | IF UNDER 24 HRS
Months Days Hours Min | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | | | 10b. KIND OF BUSINESS OR INDUSTRY
CONSTRUCTION | | 11 BIRTHPLACE (County & State or foreign country)
CULPEPPER, VIRGINIA | |
| 12 CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13 FATHER'S NAME
GEORGE TAILEY | | | | 14 MOTHER'S MAIDEN NAME
BELLE PARKER | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WWI | | | | 16. SOCIAL SECURITY NO.
218 05 78 89 | | 17. INFORMANT
CLINICAL RECORDS, VAH, FT. HOWARD, MD. | |
| 18 CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a). CHRONIC HEART FAILURE
4x100 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). AFTERIOSCLEROSIS HEART DISEASE
DUE TO
(c). | | | | INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN
YEARS | | | |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that 20 (this hospital) attended the deceased from MARCH 5, 1967 to MAY 27, 1967 , that we last saw the deceased alive on MAY 27, 1967 , and that death occurred at 8:50 PM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Z. S. Tao | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
5/27/67 | |
| 22c. PHYSICIAN'S NAME (Type)
ZUI-SUN TAO, M.D. | | | | 22d. ADDRESS
VAH, FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
5/31/67 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR
ADOLPHUS HALSTEAD FUNERAL HOME | | | | ADDRESS
1206 W. North Ave. BALTO., MD. | | 25a. REC'D BY REGISTRAR
MAY 29 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

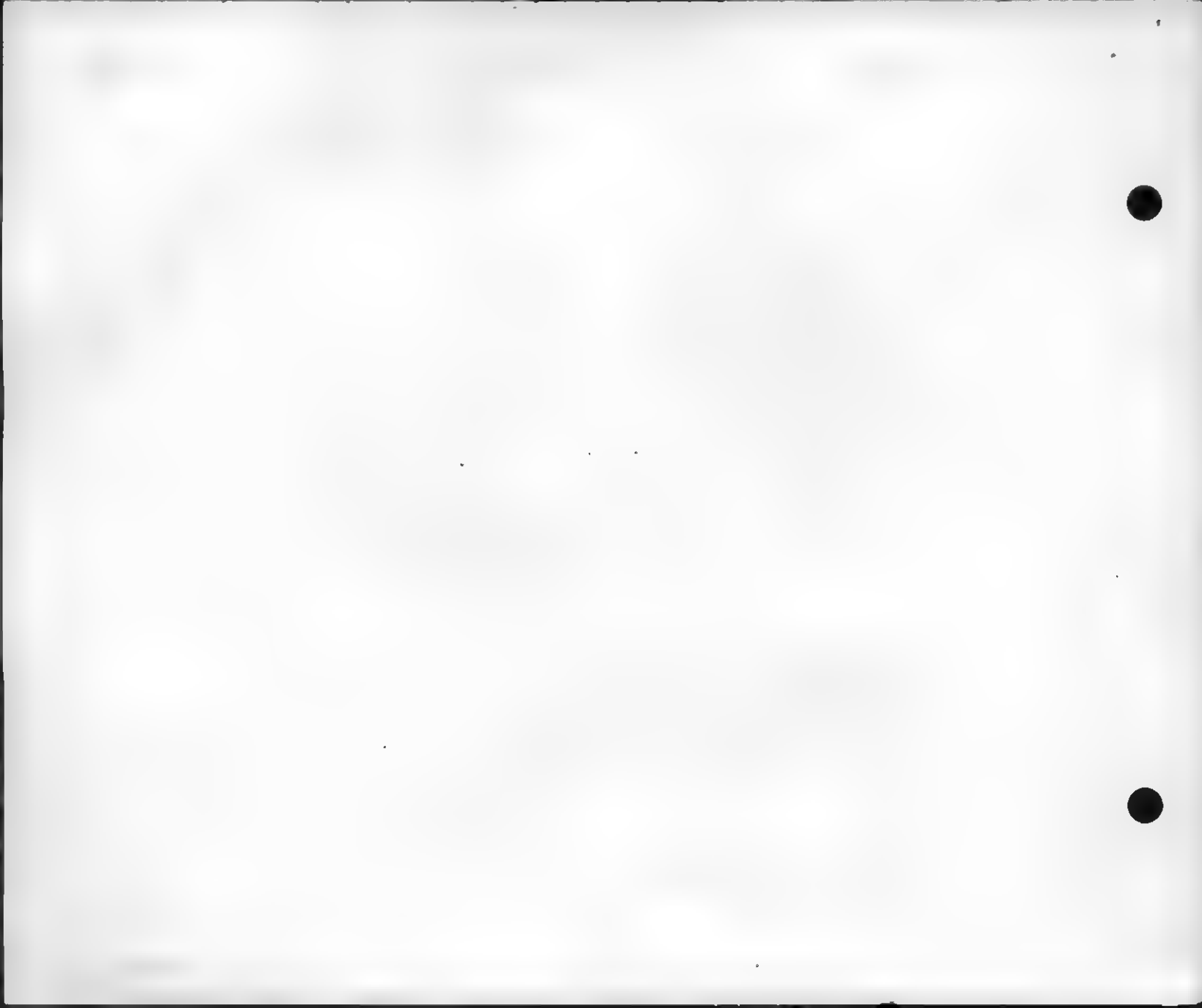
CERTIFICATE OF DEATH

JE225

26436

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|---|--|
| 1 PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
b. COUNTY MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
6001 UPDALE COURT | | d. STREET ADDRESS
6001 UPDALE COURT | |
| 3 NAME OF DECEASED (Type or print)
First MARTIN Middle TANNER Last | | 4 DATE OF DEATH MAY 14, 1967 19 | |
| 5 SEX MALE | 6 COLOR OR RACE WHITE | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 12/25/1892 |
| 9 AGE (in years last birthday) 74 yrs | | 10 UNDER 1 YEAR Months Days Hours Min. | |
| 11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED-RAILROAD | | 11b KIND OF BUSINESS OR INDUSTRY
ATLANTIC COAST LINE | |
| 11 BIRTHPLACE (County & State, or foreign country)
BROOKLYN, NEW YORK | | 12 CITIZEN OF WHAT COUNTRY?
USA | |
| 13 FATHER'S NAME
HENRY TANNER | | 14 MOTHER'S MAIDEN NAME
SARAH GELLER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES ARMY WW I | | 16. SOCIAL SECURITY NO
718-12-1116 | |
| 17 INFORMANT
MRS. SYBIL TANNER WHITE | | Address
6001 UPDALE COURT | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
DUE TO (b) Arteriosclerotic cardiovascular disease
DUE TO (c) with prior myocardial infarction Jan 67
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | INTERVA. BETWEEN ONSET AND DEATH
1 hr
6 mos |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 1963 , to May 17, 1967 that (I) (we) last saw the deceased alive on May 12 1967 , and that death occurred at 10 P M , from causes and on the date stated above. | | | |
| 22a SIGNATURE
DR. MARVIN DAVIS | | 22b DATE SIGNED
May 15, 1967 | |
| 22c PHYSICIAN'S NAME (Type)
DR. MARVIN DAVIS | | 22d ADDRESS
6512 LIBERTY ROAD | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b DATE THEREOF
5/16/67 | 23c NAME OF CEMETERY OR CREMATORY
HEBREW FRIENDSHIP | 23d LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND |
| 24 FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC., 6010 REIST., RD. | | 25a REC'D BY REGISTRAR
MAY 19 1967 | |
| | | 25b REGISTRAR'S SIGNATURE
J. Charles Judge | |



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

36437

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06-26

| | | | |
|--|---------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>PARKTON</u> | | c. LENGTH OF STAY IN ID
<u>Life</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>RFD #1</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>PARKTON</u> | |
| | | d. STREET ADDRESS
<u>RFD #1</u> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>SARAH Elsie Thompson</u> | | 4. DATE OF DEATH
Month Day Year
<u>MAY 26 1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Cau.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>6-22-1885</u> |
| 9. AGE (in years last birthday)
<u>81</u> yrs. | | 10. FUNDING 1 YEAR <input type="checkbox"/> 24 HRS. <input type="checkbox"/>
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>BALTO. CO. MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Joshua Wheeler</u> | | 14. MOTHER'S MAIDEN NAME
<u>Rachel Hare</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>219-30-8358D</u> | |
| 17. INFORMANT
<u>Mrs. Ethel R. Price</u> | | Address
<u>149 Liberty St. Westminister, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>C. S. C. V. Disease</u>
<u>4321</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>C. M. France</u> M.D. | | 22. DATE SIGNED
<u>5/27/67</u> | |
| EXAMINER'S NAME (Type)
<u>A. M. FRANCE</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) <u>PARKTON, MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>May 29, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>MT. CARMEL Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>PARKTON MD.</u> | |
| 24. FUNERAL DIRECTOR
<u>John E. Loff</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | |
| ADDRESS
<u>Hampstead, Md.</u> | | DATE
<u>MAY 31 1967</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

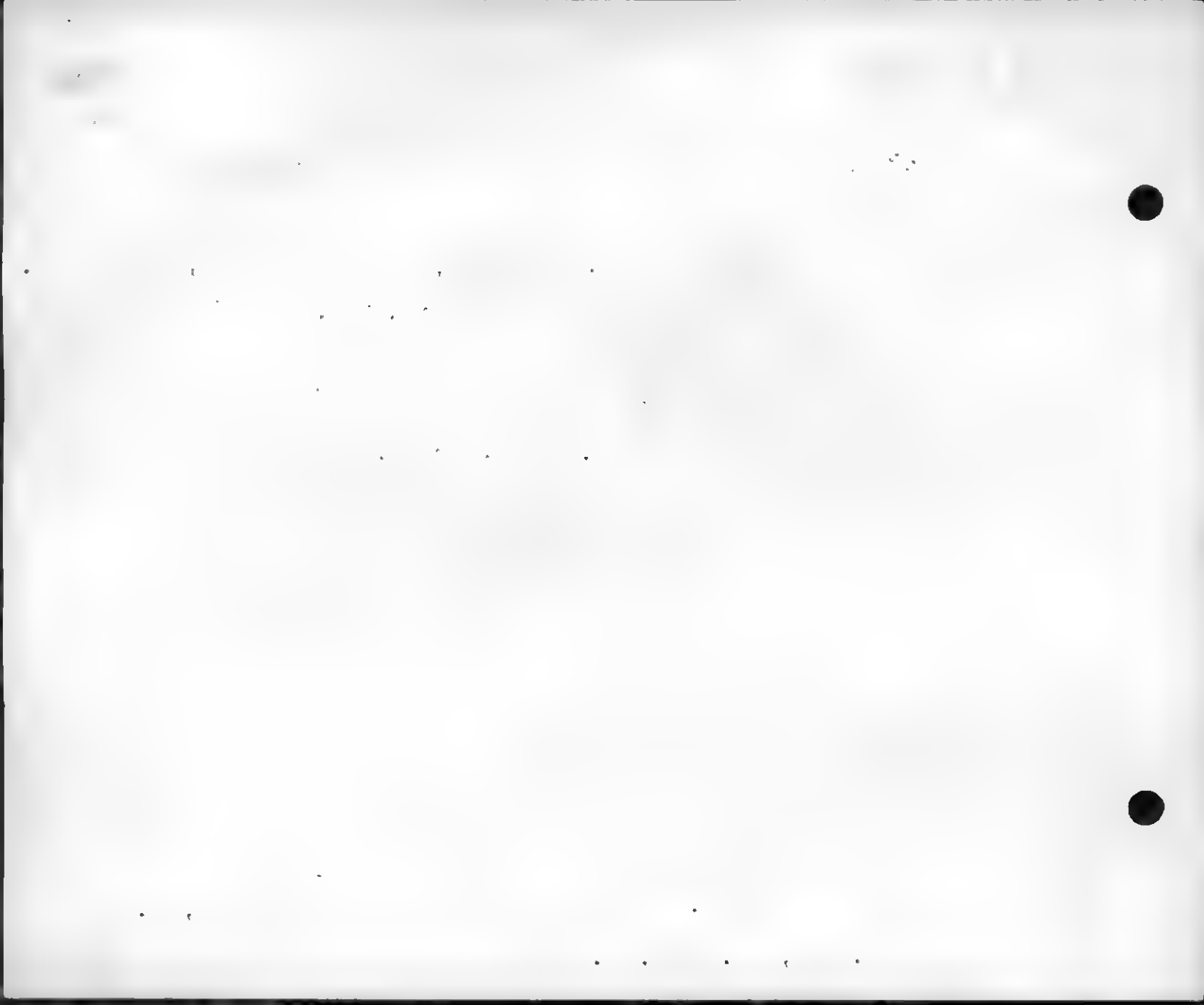
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #8 & 9 Film, 5/29/67 pc
CERTIFICATE OF DEATH

06438

06424

| | | | | | | | |
|--|----------------------------------|---|---------------------------------|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Parkville | | | | c. LENGTH OF STAY IN TOWN | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
2910 Onyx Road | | | | d. STREET ADDRESS
2910 Onyx Road | | | |
| 3. NAME OF DECEASED (Type or print)
First RANDOLPH Middle H. Last THRASHER, SR. | | | | 4. DATE OF DEATH
Month May Day 19 Year 1967 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1906 | 9. AGE (In years last birthday)
60 | IF UNDER 1 YEAR
Months Days Hours Min | | IF UNDER 24 HRS
Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Letter Carrier Post Office | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | 13. FATHER'S NAME
William Thrasher | | | |
| 14. MOTHER'S MAIDEN NAME
Eleanor Simmons | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
Unk. | | | | 17. INFORMANT
Mrs. Verna L. Thrasher Address (Same) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) DUE TO
(c) | | | | | | | INTERVA. BETWEEN ONSET AND DEATH
13 yrs |
| PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
none | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that (I) (this hospital) attended the deceased from 3. 23 , 19 54 , to 5. 19 , 19 67 , that (I) (we) last saw the deceased alive on 5. 4 , 19 67 , and that death occurred at 4 P M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
[Signature] | | | | 22b. DATE SIGNED
5. 20 67 | | 22c. PHYSICIAN'S NAME (Type)
DR. JOS. SKLOVEN | |
| 22d. ADDRESS
7122 Hopson P. Baltimore | | | | 23a. B. RIAL, CREMATION, REMOVAL (Specify)
Burial | | | |
| 23b. DATE THEREOF
5/23/67. | | | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | 25a. REC'D BY REGISTRAR
DATE MAY 22 1967 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36433

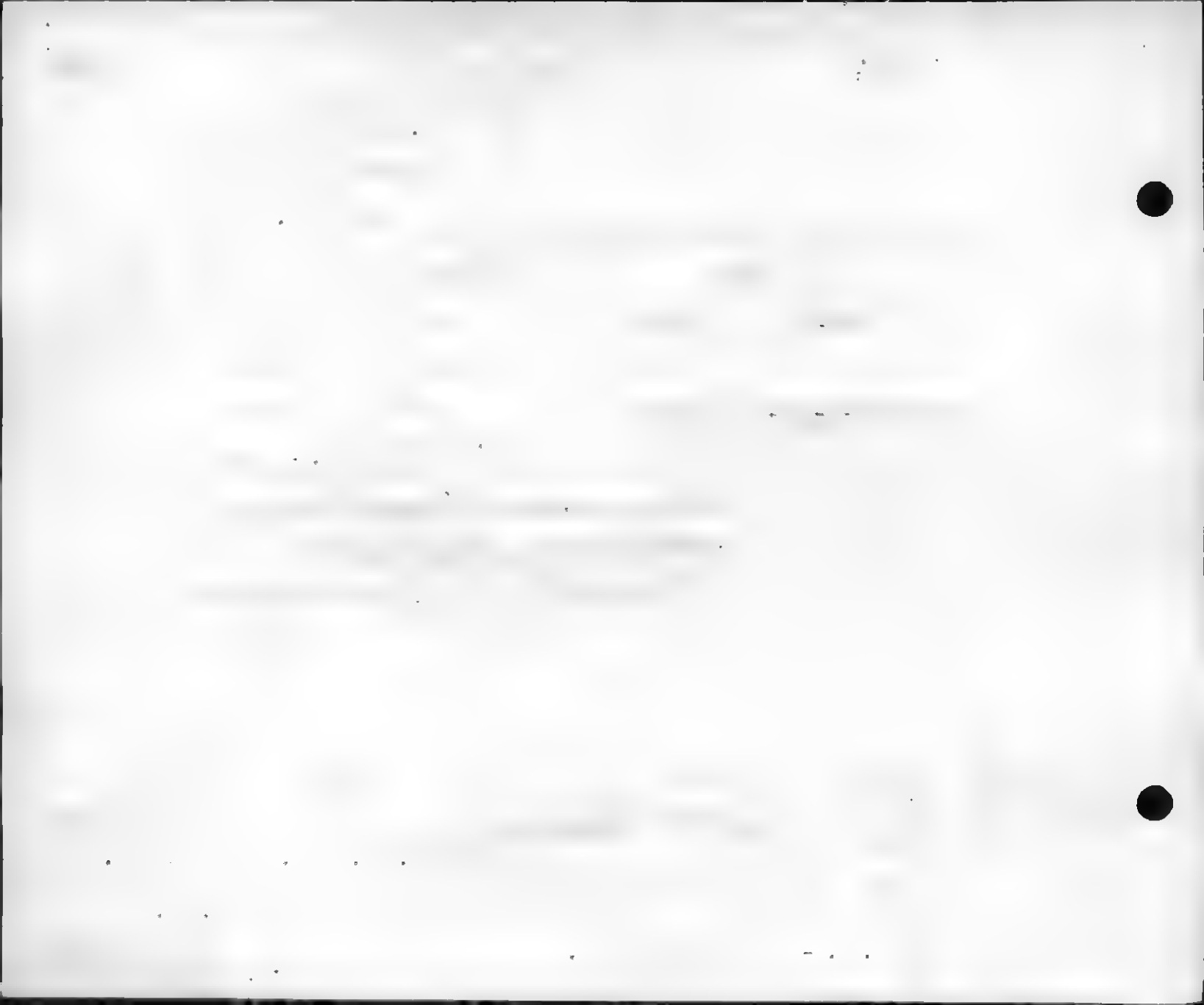
CERTIFICATE OF DEATH

15128

| | | | |
|--|---|--|---|
| 1 PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if inst put on Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Baltimore County General Hospital.</u> | | d. STREET ADDRESS
<u>1523 Kirkwood Rd.</u> | |
| 3 NAME OF DECEASED
(Type or print)
First <u>Eva</u> Middle <u>F.</u> Last <u>Wilen</u> | | 4 DATE OF DEATH
Month <u>5</u> Day <u>29</u> Year <u>1967</u> | |
| 5 SEX <u>F.</u> | 6 COLOR OR RACE <u>white</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
<u>1-6-95</u> |
| 9. AGE (n years last birthday) <u>72</u> yrs | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (County & State, or foreign country)
<u>Balt., Maryland</u> | | 12 CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Charles Koeneke</u> Koeneke | | 14. MOTHER'S MAIDEN NAME
<u>Katherine Dreschler</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16 SOCIAL SECURITY NO | |
| 17. INFORMANT
<u>Mrs. Lena Koerber</u>
<u>1521 Clairidge Rd. - 21207</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Pulmonary Fibrosis</u>
DUE TO
(c) <u>Pulmonary Emphysema</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5-19-1967</u> to <u>5-29-1967</u> , that (I) (we) last saw the deceased alive on <u>5-19-1967</u> , and that death occurred at <u>2:45</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>[Signature]</u> | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22b. DATE SIGNED
<u>5-29-67</u> |
| 22c. PHYSICIAN'S NAME (Type)
<u>Stephen Lai</u> | | 22d. ADDRESS
<u>Balto. Co. Hosp., Old Court Rd.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>6/1/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Baltimore National</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Witzke F. D. - 4101 Edmondson Ave.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 31 1967</u> | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



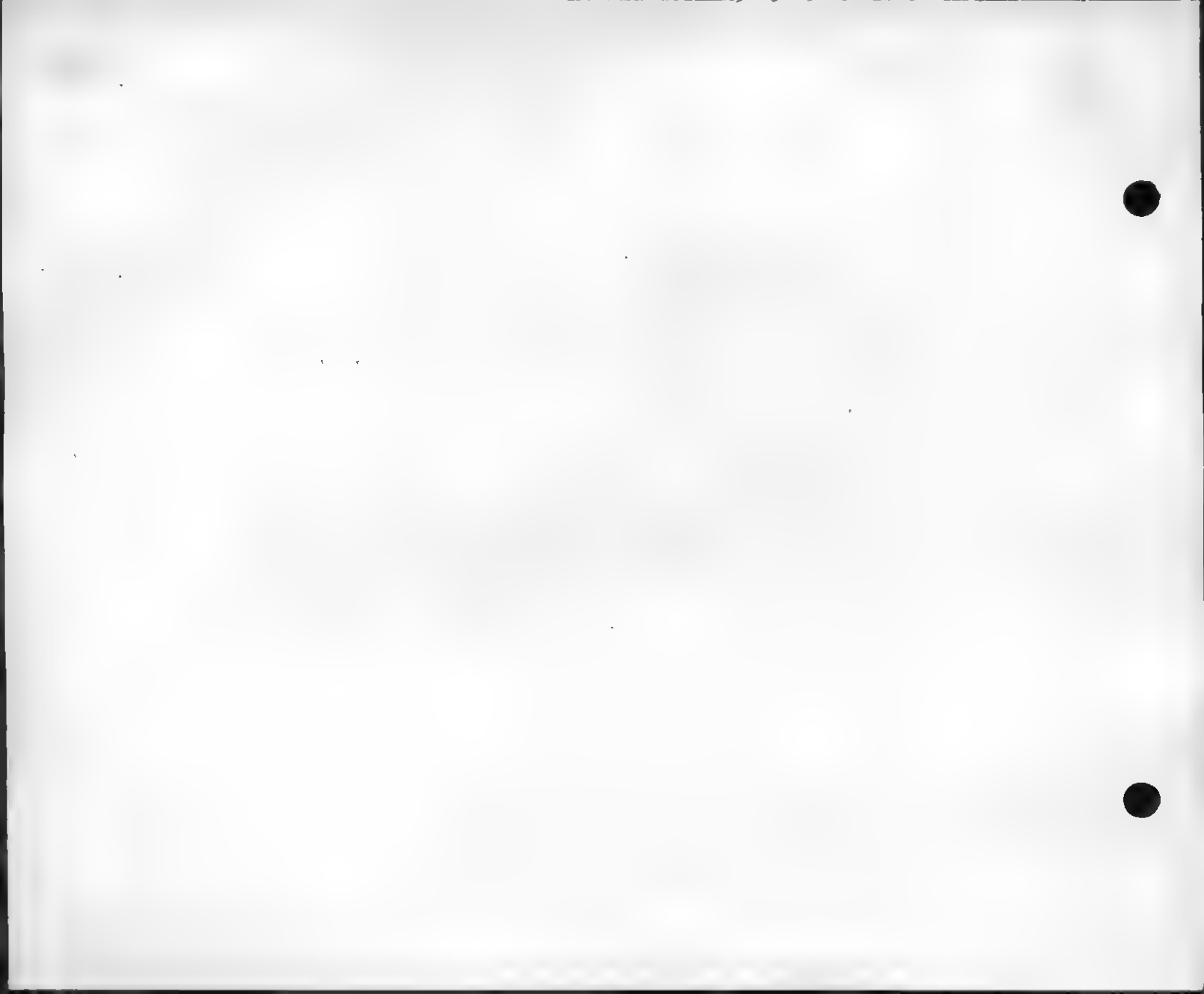
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>
c. LENGTH OF STAY IN ID
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>131 Elinor Avenue</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>
d. STREET ADDRESS <u>131 Elinor Ave.-21236</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Edward F. Tilling Sr.</u>
First Middle Last
5. SEX <u>Male</u>
6. COLOR OR RACE <u>White</u>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 8. DATE OF BIRTH <u>12-28-1900</u>
9. AGE (in years last birthday) <u>66</u> yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min. | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman-Water Meter Repair</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. City</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Ilchester, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | 13. FATHER'S NAME <u>Joseph V. Tilling</u>
14. MOTHER'S MAIDEN NAME <u>Lulu Marie Hanes</u> | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. <u>214-20-3426</u> | | 17. INFORMANT <u>Mary (Marie) C. Tilling-131 Elinor Ave.</u> Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u>
DUE TO (b) <u>Bronchogenic carcinoma</u>
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ACVD & chronic atrial fibrillation.</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
1 yes? <u>2</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>62</u> , to <u>10 May</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9 May</u> , 19 <u>67</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>John C. Hyde</u>
22c. PHYSICIAN'S NAME (Type) <u>JOHN C. Hyde</u> | | | | | 22d. ADDRESS <u>7527 Belair Rd Balto 36 Md</u> | | 22b. DATE SIGNED <u>5-11-67</u>
M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE THEREOF <u>5-13-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u> | | | | |
| 24. FUNERAL DIRECTOR <u>John C. Miller Inc.-6415 Belair Rd.-21206</u> ADDRESS | | | | | 25a. REC'D BY REGISTRAR <u>MAY 15 1967</u> DATE | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | |

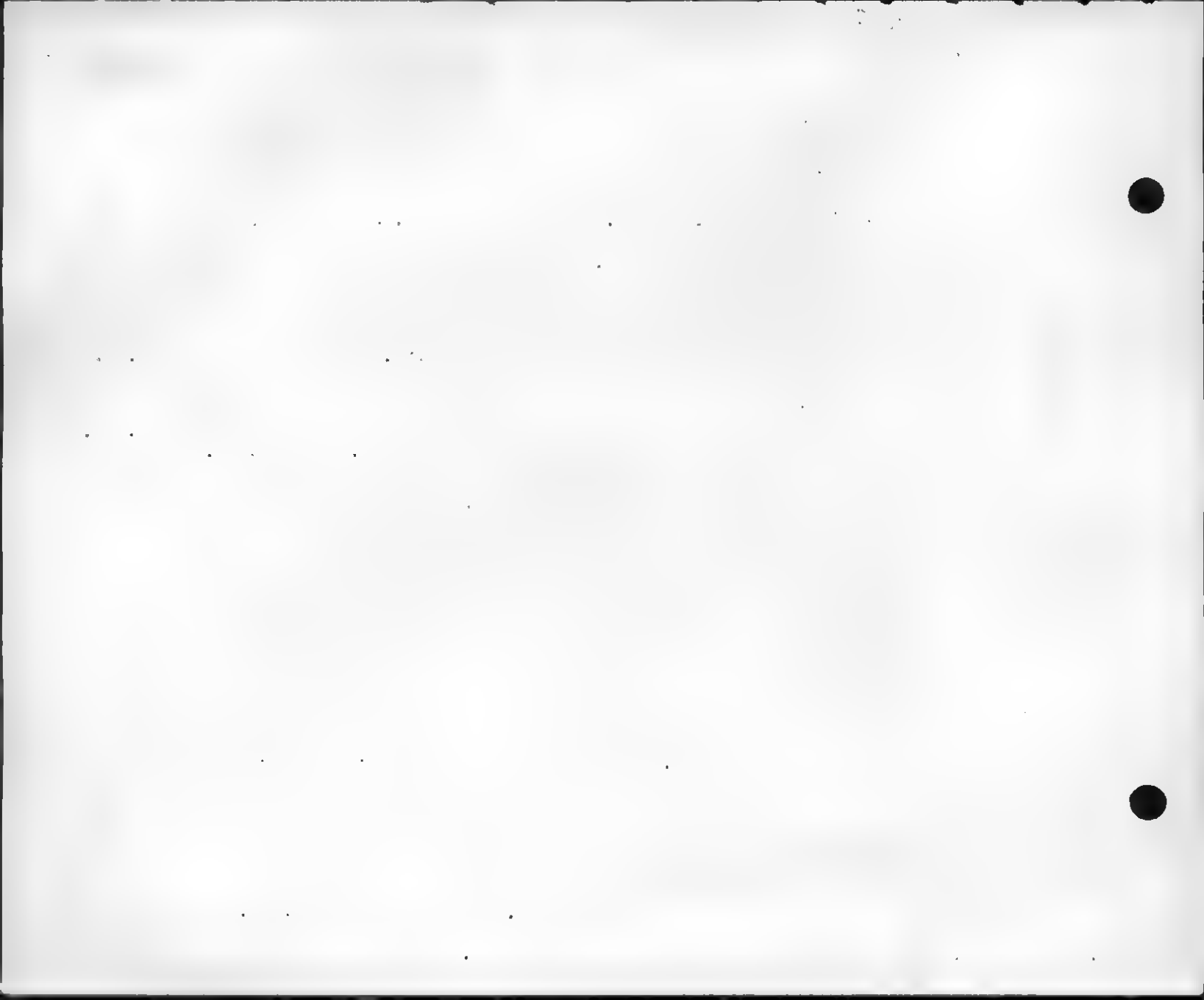
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Catonville</u>
c. LENGTH OF STAY IN ID <u>1 Week</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>House In The Pine, Passing Ave.</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u>
b. COUNTY _____
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u>
d. STREET ADDRESS
<u>307 S. Augusta Ave.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
<u>Elmira N. Travers</u>
4. DATE OF DEATH
May 26, 1967 | | 5. SEX <u>Female</u>
6. COLOR OR RACE <u>White</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH
<u>July 2, 1878</u>
9. AGE (in years last birthday) <u>88</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>House Wife</u>
10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (County & State, or foreign country)
<u>Balto. Md.</u>
12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | 13. FATHER'S NAME
<u>George Aaron</u>
14. MOTHER'S MAIDEN NAME
<u>Amelia Kriel</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) _____
16. SOCIAL SECURITY NO. _____
17. INFORMANT
<u>Mrs. Margaret G. Banks</u> Address <u>307 S. Augusta Ave.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
(b) <u>Atherosclerotic CV Disease</u>
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 wk.</u>
<u>2 yr.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____
20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. _____ 19____
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) (County) (State) _____ | | 21. I certify that (I) (this hospital) attended the deceased from <u>4-1-1958</u> , to <u>5-26-1967</u> , that (I) (we) last saw the deceased alive on <u>5-26-1967</u> , and that death occurred at <u>12:20 PM</u> , from the causes and on the date stated above.
22a. SIGNATURE <u>John F. Schaefer</u>
22b. DATE SIGNED <u>5/28/67</u>
22c. PHYSICIAN'S NAME (Type) _____
22d. ADDRESS _____ | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u>
23b. DATE THEREOF
<u>May 29, 1967</u>
23c. NAME OF CEMETERY OR CREMATORY
<u>Woolly m. Cem.</u>
23d. LOCATION (City, town or county) (State)
<u>Balto. Md.</u> | | 24. FUNERAL DIRECTOR
<u>G. Truman Schrab</u> <u>3512 Frederick Ave, Balto. Md.</u>
25a. REC'D BY REGISTRAR <u>MAY 31 1967</u>
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

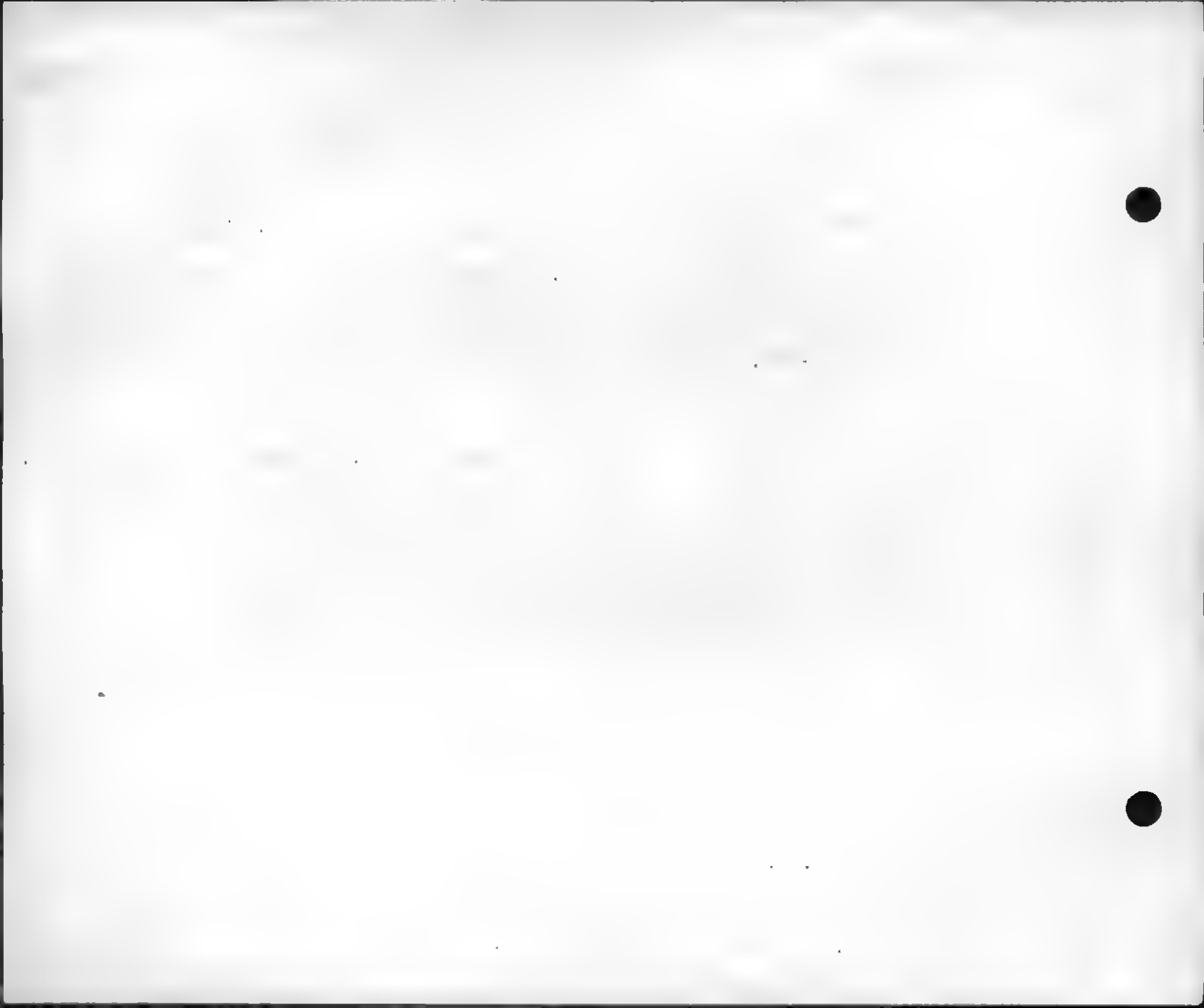
CERTIFICATE OF DEATH

06442

06231

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---|---|--|
| 1 PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
c. LENGTH OF STAY IN lb
Baltimore | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| 3 NAME OF DECEASED (Type or print)
First Jay Middle H. Last Treiber | | 4. DATE OF DEATH
Month May Day 21 Year 1967 | |
| 5 SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 7/11/99 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Electrician - Ret. | | 10b. KIND OF BUSINESS OR INDUSTRY
Western Union | 9. AGE (In years last birthday) 67
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min |
| 11 BIRTHPLACE (County & State or foreign country)
Pennsylvania | | 12 CITIZEN OF WHAT COUNTRY?
USA | |
| 13 FATHER'S NAME
Herbert Treiber | | 14 MOTHER'S MAIDEN NAME
Elizabeth Sheely | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16 SOCIAL SECURITY NO
215-03-7490 | |
| 17. INFORMANT
Mrs. Helen I. Treiber | | Address 4314 Barrington Rd. 21229 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary edema
21 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Pulmonary emphysema
DUE TO
(c) A. S. C. V. disease | | | INTERVAL BETWEEN ONSET AND DEATH
3 hours
5 years
? |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from March , 1962 to May 21 , 1967, that (I) (we) saw the deceased alive on May 20 , 1967, and that death occurred at 6 A. M. , from causes and on the date stated above. | | | |
| 22a SIGNATURE
D. C. MacLaughlin | | 22b DATE SIGNED
5/22/67 | |
| 22c PHYSICIAN'S NAME (Type)
D. C. MacLaughlin | | 22d ADDRESS
303 N. Rolling Rd. | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b DATE THEREOF
5/24/67 | 23c NAME OF CEMETERY OR CREMATORY
Lorraine Cemetery | 23d LOCATION (City or town) (County) (State)
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard | | 25a. REC'D BY REGISTRAR
MAY 25 1967 | |
| ADDRESS
4107 Wilkens Ave. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |



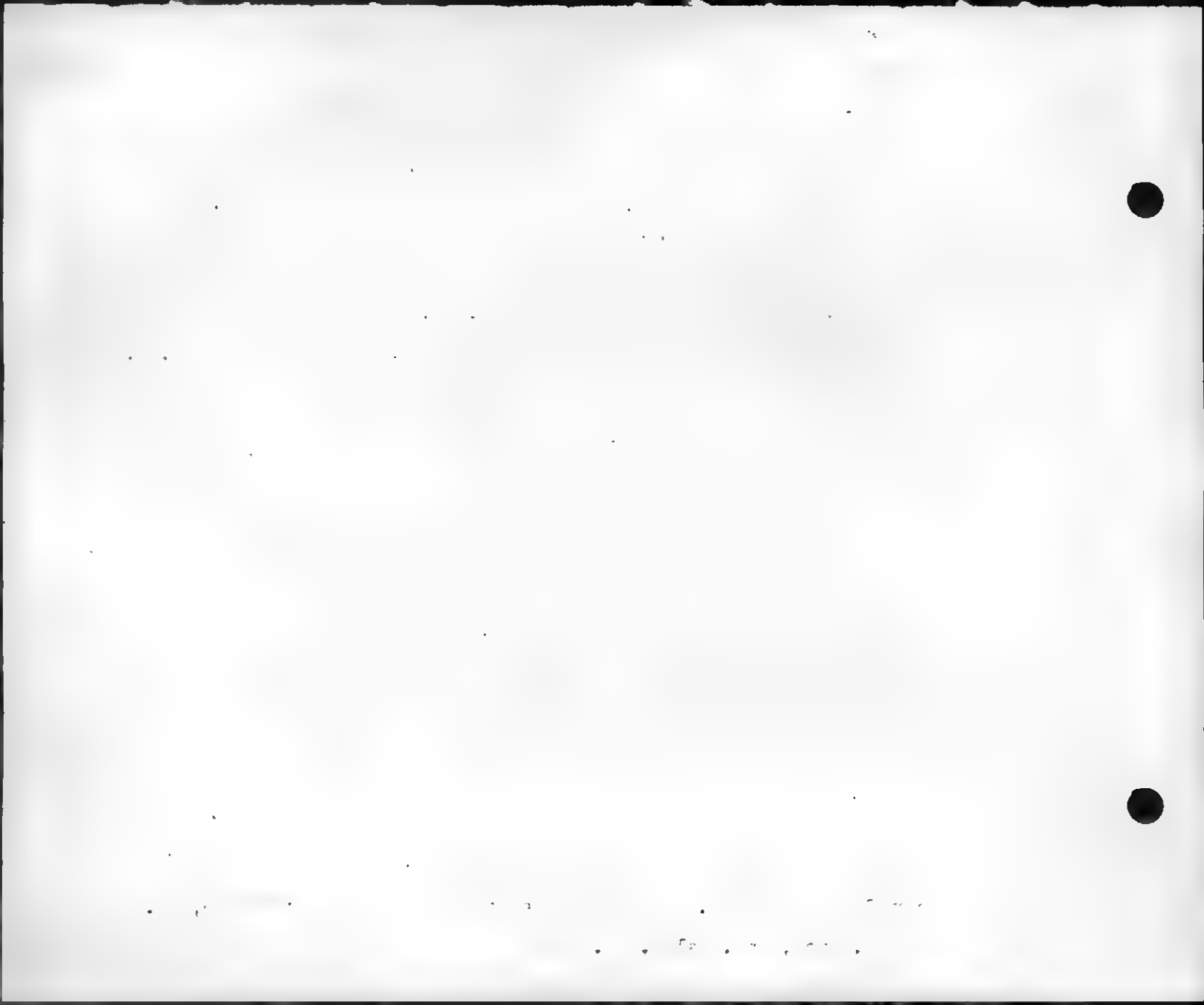
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville
c. LENGTH OF STAY IN 1b 32yr10mth3dys
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 1819 East 29th Street
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) WILLIAM KERR
First WILLIAM Middle Kerr Last TURNER | | 4. DATE OF DEATH MAY 21 1967
Month MAY Day 21 Year 1967 | |
| 5. SEX male
6. COLOR OR RACE white
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 28, 1909
9. AGE (in years last birthday) 57 yrs.
IF UNDER 1 YEAR: Months 57 Days 57 Hours 57 Min. 57 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer
10b. KIND OF BUSINESS OR INDUSTRY factory | | 11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME ? Koester | | 14. MOTHER'S MAIDEN NAME Kate Morgan | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. None | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL
Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EMBOLISM
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. LATE COMPLICATION FOLLOWING SURGERY
DUE TO (b) LATE COMPLICATION FOLLOWING SURGERY
DUE TO (c) LATE COMPLICATION FOLLOWING SURGERY
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
Hours
days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. 19
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (if this hospital) attended the deceased from July 19 , 19 64 , to MAY 21 , 19 67 , that (he) last saw the deceased alive on MAY 21 , 19 67 , and that death occurred at 20 A.M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE George A Rodin
22c. PHYSICIAN'S NAME (Type) George A Rodin | | 22b. DATE SIGNED 5-21-67
22d. ADDRESS SPRING GROVE ST HOSP | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 5/24/67.
23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery
23d. LOCATION (City, town or county) (State) Baltimore, Md. | | 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214
ADDRESS | |
| 25a. REC'D BY REGISTRAR MAY 24 1967
DATE | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

06444

06433

| | | | | | | | |
|--|-----------------------------|--|---------------------------------------|--|--|--|------------------------------|
| 1. PLACE OF DEATH
a COUNTY <u>BALTO</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE <u>MD.</u> b COUNTY <u>BALTO</u> | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>ESSEX</u> | | c LENGTH OF STAY IN 1b | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>ESSEX</u> | | | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>FRANKLIN AVE. UHL</u> | | | | d. STREET ADDRESS
<u>528 FRANKLIN AVE</u> | | e IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
<u>528 FRANKLIN AVE</u> First Middle Last
<u>Franklyn Ave Uhl</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>MAY 29 1967</u> | | | |
| 5 SEX
<u>M</u> | 6 COLOR OR RACE
<u>W</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
<u>MAY 30 1893</u> | 9 AGE (in years lost birthday) yrs
<u>73</u> | 10 UNDER 1 YEAR
Months Days Hours Min | | 11 UNDER 24 HRS
Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>CARDER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (State or foreign country)
<u>MD.</u> | | 12 CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13 FATHER'S NAME
<u>ADAM UHL</u> | | | | 14 MOTHER'S M A D E N NAME
<u>MARY BOHL</u> | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>UNK</u> | | 16 SOCIAL SECURITY NO | | 17 INFORMANT
<u>LILLIAN UHL</u> | | Address
<u>ABOVE</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>
<u>4201</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | 20c PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) | | 20f (City or town) (County) (State) | |
| 20d TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
<u>Theo C. Peterson</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22 DATE SIGNED
<u>5/29/67</u> | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Address (Street, city, town, or county) | | | | 23a BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b DATE THEREOF
<u>6/1/67</u> | |
| 24 FUNERAL DIRECTOR
<u>JG CONNELLY</u> | | | | 23c NAME OF CEMETERY OR CREMATORY
<u>SACRED HEART</u> | | 23d LOCATION (City or Town) (County) (State)
<u>BALTO. MD.</u> | |
| 25a REG. BY REG. STRAR
<u>JUN 1 1967</u> | | | | 25b REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06445

06434

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Owings Mills

c. LENGTH OF STAY IN 1b

49 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Timber Grove Road

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Owings Mills

d. STREET ADDRESS

Timber Grove Road

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

Lucy

Middle

Lee

Last

Utz

4. DATE OF DEATH

Month

May

Day

1,

Year

19 67

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

☐ NEVER MARRIED ☐

☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

July 21, 1880

9. AGE (In years last birthday)

77 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Madison Co., Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Carpenter

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-48-1993

17. INFORMANT

Mrs. Evelyn A. Ebaugh, Westminister, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Uremia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Arterio sclerotic C.V. Disease

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Partial paralysis rt. arm & leg.

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.
p.m.

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from April 28, 1967, to May 1, 1967, that (I) (we) last saw the deceased alive on April 30, 1967, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

Martin E. Strobel

M.D.

ATTENDING PHYS. ☒

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

Martin E. Strobel

22d. ADDRESS

Reisterstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF
May 1, 1967

23c. NAME OF CEMETERY OR CREMATORY

All Saints Cemetery

23d. LOCATION (City, town or county)

Reisterstown, Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

H. J. Eckhardt

ADDRESS

Owings Mills, Md.

25a. REC'D BY REGISTRAR

MAY 4 1967

25b. REGISTRAR'S SIGNATURE

Charles Judge

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06446

CERTIFICATE OF DEATH

06435

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>House In The Pines</u> | | d. STREET ADDRESS
<u>2833 Frederick Ave. 21223</u> | |
| 3. NAME OF DECEASED
(Type or print) First <u>HENRY</u> Middle <u>E.</u> Last <u>VELTEN</u> | | 4. DATE OF DEATH
Month <u>May</u> Day <u>8</u> Year <u>1967</u> | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3/14/88</u> |
| 9. AGE (In years last birthday)
<u>79</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Motorman - retired</u> | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>John H. Veltan</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Wilamena Lentz</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO | | 17. INFORMANT Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CONGESTIVE FAILURE</u>
1810 DUE TO <u>BRONCHOPNEUMONIA</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
(b) DUE TO <u>CHRONIC URINARY TRACT INFECTION</u>
(c) <u>CARCINOMA URINARY BLADDER</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3-11</u> , 19 <u>67</u> , to <u>5-8</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>5-8</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> P.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>D. C. Sorongon</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>DOMINGO C. SORONGON, M.D.</u> | | 22d. ADDRESS <u>3915 HOLLINS FERRY RD, BALTIMORE MD. 21227</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>5/12/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Western Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>Howard H. Hubbard</u> | | 25a. REC'D BY REGISTRAR
<u>4107 Wilkens Ave. 21229</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | | DATE
<u>MAY 10 1967</u> | |



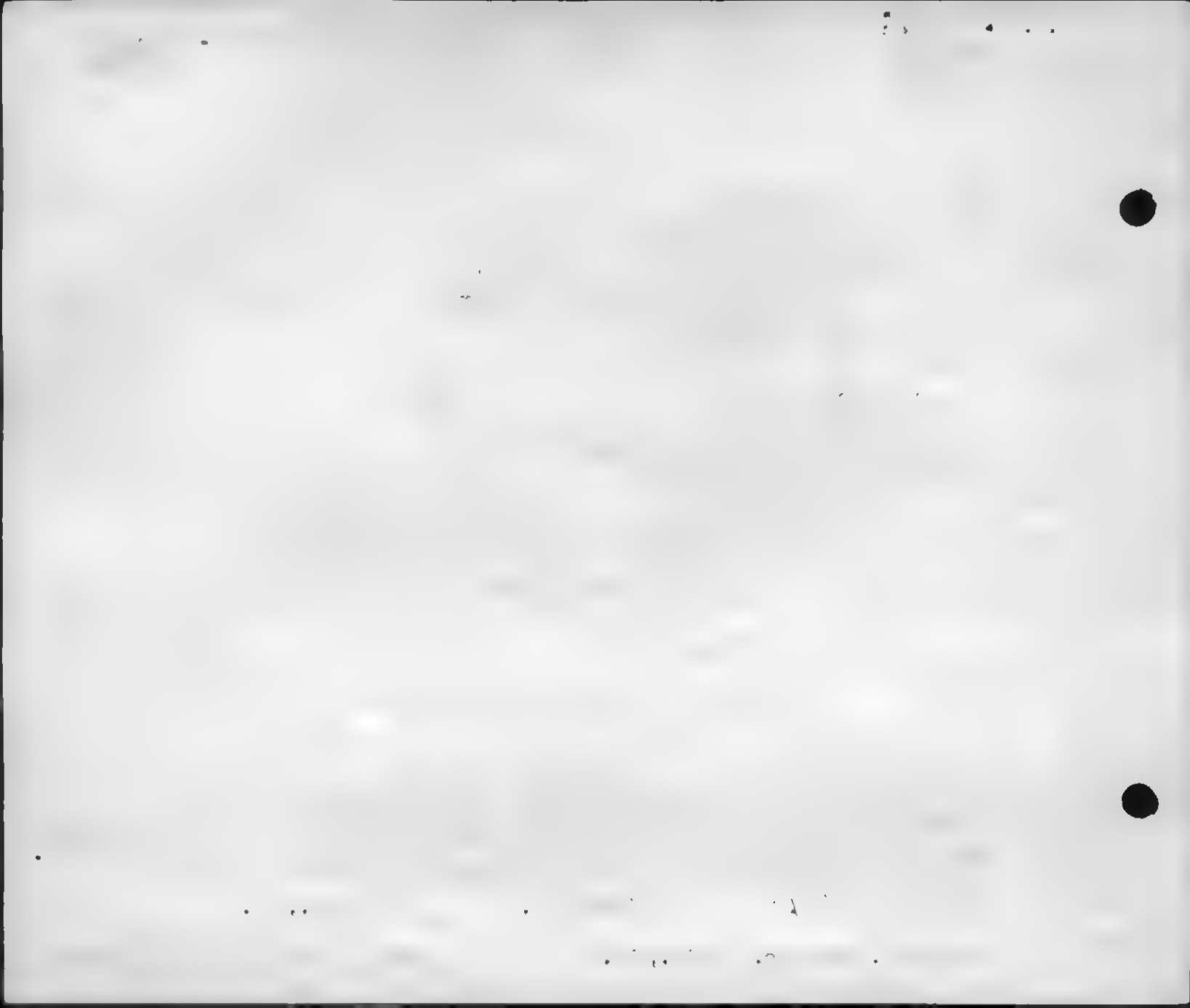
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if within corporate limits, write RURAL and give nearest town) Balto
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4208 Silver Spring Rd
2. USUAL RESIDENCE (where deceased lived, if institution, Residept. place address on)
a. STATE Md b. COUNTY Balto
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Balto Md
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) First Middle Last James Holden Vetter
4. DATE OF DEATH Month Day Year May 28 1967
5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 11/25/02 9. AGE (In years, if UNDER 1 YEAR, last birthday) Months Days Hours Min. 64
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gambler (Retired 7-8 yrs) 10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Vetter 14. MOTHER'S MAIDEN NAME Olive Payne
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 214-01-9409 INFORMANT Margaret Vetter Address 4208 Silver Spring
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Artery Occlusion
DUE TO (b) Coronary Artery Disease
DUE TO (c) Atherosclerotic Cardiovascular Disease
INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 31
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE F. T. KASIK JR. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ M.D. DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) F. T. KASIK JR. Address (Street, city, town, or county) 9005 Hopkins Rd DATE SIGNED 5/31/67
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 5/31/67 22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem. 22d. LOCATION (City, town, or country) (State) Balto., Md.
23. FUNERAL DIRECTOR Leonard J. Ruck Inc. ADDRESS Balto., Md. 24a. REC'D BY REGISTRAR Charles Judge 24b. REGISTRAR'S SIGNATURE
DATE MAY 31 1967



1
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4

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

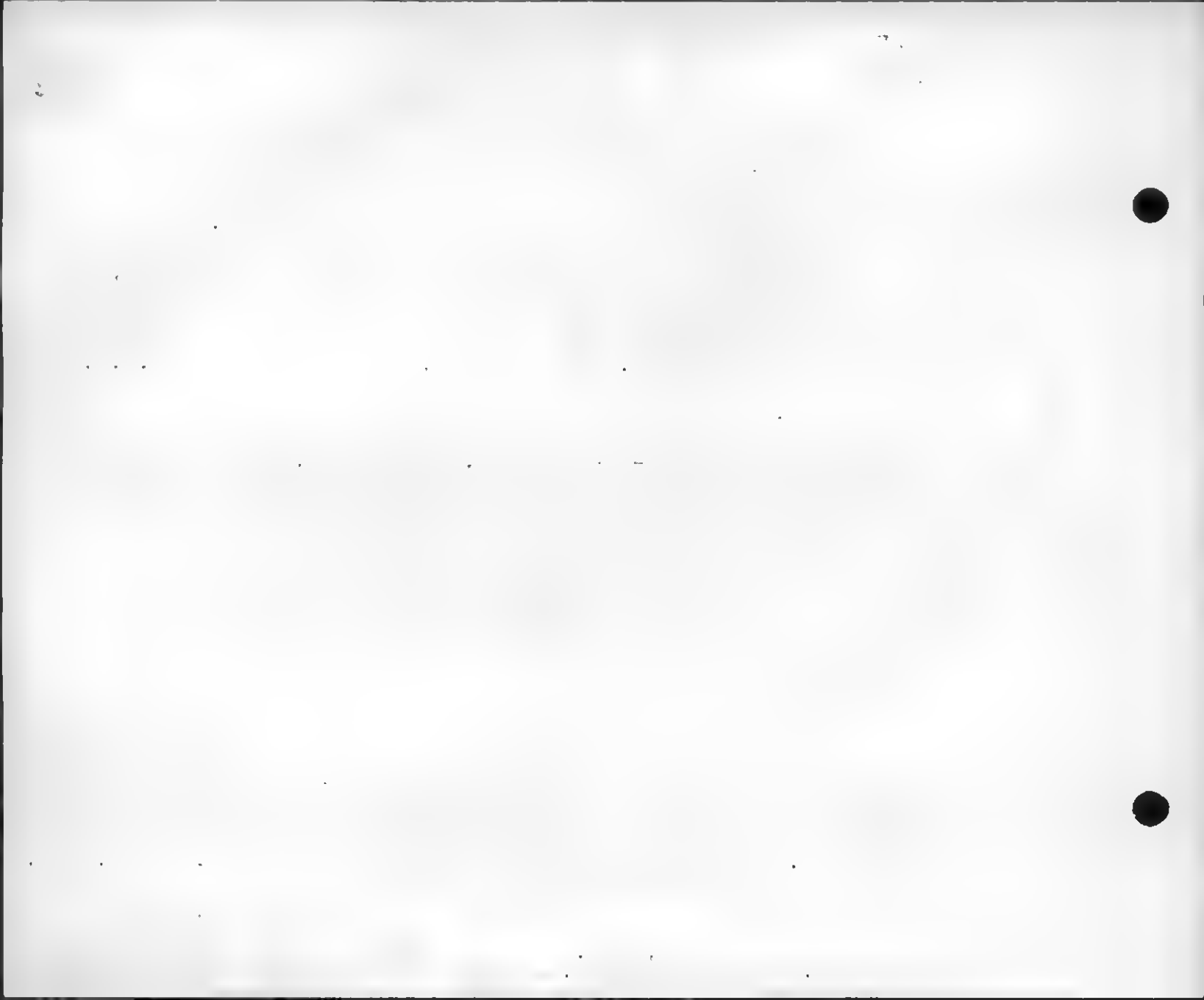
36443

1967

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|---|---|--|
| 1 PLACE OF DEATH
a COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Anneslie</u> | | c LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>608 Windwood Road</u> | | d STREET ADDRESS <u>608 Windwood Rd.</u> | |
| 3 NAME OF DECEASED (Type or print) <u>Leonette Hogan Voelker</u> | | 4 DATE OF DEATH <u>May 10, 1967</u> | |
| 5 SEX <u>Female</u> | 6 COLOR OR RACE <u>White</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8 DATE OF BIRTH <u>April 11, 1903</u> |
| 9 AGE (In years last birthday) <u>64</u> yrs | | 10 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Personnel Officer</u> | | 10b KIND OF BUSINESS OR INDUSTRY <u>Balto. Life Ins. Co.</u> | |
| 11 BIRTHPLACE (County & State or foreign country) <u>Maryland</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13 FATHER'S NAME <u>James A. Hogan</u> | | 14 MOTHER'S MAIDEN NAME <u>Cecelia Hoffman</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16 SOCIAL SECURITY NO <u>214-18-9185</u> | |
| 17 INFORMANT <u>Mrs. Patricia L. Peroutka</u> | | Address <u>Same</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u>
<u>157X</u> DUE TO (b) <u>(pancreatic?)</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>18 mos.</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS A T.O.P.S. PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) | 20f (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>December, 1962</u> to <u>May 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 7, 1967</u> , and that death occurred at <u>8 P.M.</u> from causes and on the date stated above | | | |
| 22a SIGNATURE <u>Carlton L. Sexton</u> | | 22b DATE SIGNED <u>May 11, 1967</u> | |
| 22c PHYSICIAN'S NAME (Type) <u>Dr. Carlton Sexton</u> | | 22d ADDRESS <u>819 Park Ave. Balto., Md.</u> | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b DATE THEREOF <u>5-12-67</u> | 23c NAME OF CEMETERY OR CREMATORY <u>Parkwood</u> | 23d LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> |
| 24 FUNERAL DIRECTOR ADDRESS <u>Mitchell-Wiedefeld Home, Inc.</u>
<u>6500 York Rd. Baltimore, Md. 21212</u> | | 25a REC'D BY REGISTRAR DATE <u>MAY 12 1967</u> | |
| | | 25b REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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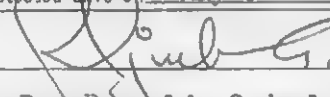

VR A15 (4)
20 M 1/66

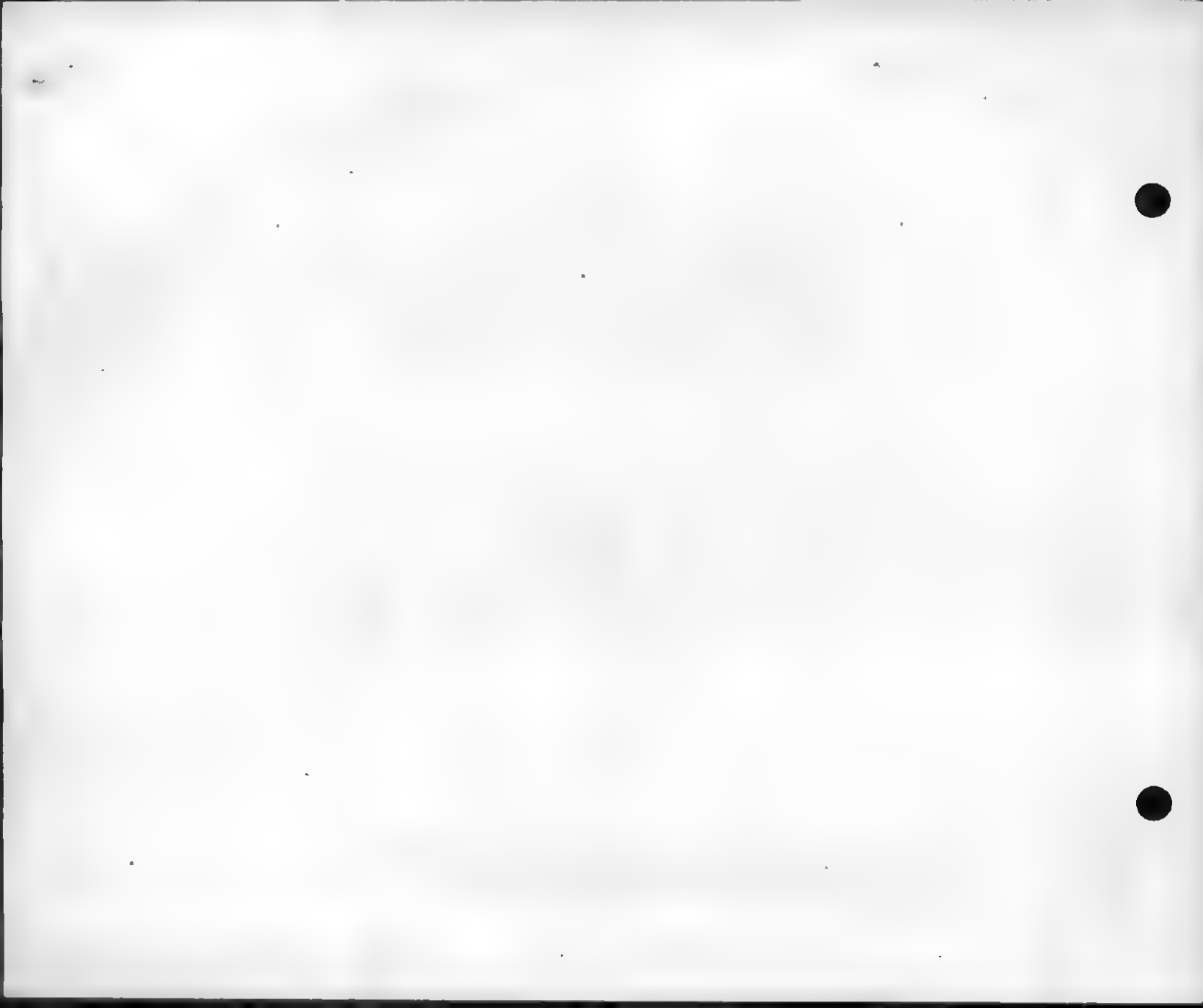
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06443

06438

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN 1b
7 Months | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | d. STREET ADDRESS
216 Eastspring Rd. 21093 | |
| 3. NAME OF DECEASED (Type or print)
First Louis Middle J. Last Voluz | | 4. DATE OF DEATH
Month May Day 6 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/22/82 |
| 9. AGE (In years last birthday)
85 yrs. | | 10. IF UNDER 1 YEAR
Months 6 Days 19 Hours 19 Min 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Walter | |
| 11. BIRTHPLACE (County & State, or foreign country)
Switzerland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Joseph Voluz | | 14. MOTHER'S MAIDEN NAME
Angeline Gaillard | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
064 03 7764 | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Pyonephrosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prostatic Hypertrophy
DUE TO
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Renal Cell Carcinoma | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (this hospital) attended the deceased from April 27 , 19 67 , to May 6 , 19 67 , that (I) (we) last saw the deceased alive on May 6 , 19 67 , and that death occurred at 10:20pm from causes and on the date stated above. | | | |
| 22a. SIGNATURE
 | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Reynaldo Orjuela-Gomez | | 22d. ADDRESS
7620 York Rd., Baltimore, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-11-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Mt St. Marys | | 23d. LOCATION (City or Town) (County) (State)
Flushing N.Y. | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, Towson, Md. | | 25a. REC'D BY REGISTRAR
MAY 10 1967 | |
| 25b. REGISTRAR'S SIGNATURE
 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 5-63

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--------------------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 06450 06439 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <u>MD</u> b. COUNTY <u>✓</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | | | |
| c. LENGTH OF STAY IN TB <u>6 days</u> | | | | | | d. STREET ADDRESS <u>2153 Sidney Ave</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>House In The Pines</u> | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Edward E. Wahl</u> | | | | | | 4. DATE OF DEATH
Month Day Year
<u>5 / 9 / 1967</u> | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>3/2/1910</u> | | 9. AGE (In years last birthday) <u>57</u> yrs. | | IF UNDER 1 YEAR
Months Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Glass Cutter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Glass Co. Carr-Lowery</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | |
| 13. FATHER'S NAME <u>Ernest E. Wahl</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Lillian M. Gentrum</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | | | 16. SOCIAL SECURITY NO. <u>-</u> | | | | | |
| 17. INFORMANT <u>Mrs Francis Coleman Wahl</u> | | | | | | Address <u>above</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Ca of Brain</u>
Conditions, if any, which gave rise to immediate cause (b) <u>Primary Ca of Lung</u>
(c) <u>due to</u>
(a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u> | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
<u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5-3-1967</u> to <u>5-9-1967</u> , that (I) (we) last saw the deceased alive on <u>5-8-1967</u> , and that death occurred at <u>2458</u> from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Wilmer K. Gallagher</u> | | | | | | 22b. DATE SIGNED <u>5/9/67</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher, M.D.</u> | | | | | | 22d. ADDRESS <u>6209 Frederick Ave. Baltimore 21208, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>5/10/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Green Haven Cem.</u> | | 23d. LOCATION (City, town or county) <u>Pitchee Hwy</u> (State) <u>MD</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Lawan & Son Inc</u> | | | | | | 25a. REC'D BY REGISTRAR <u>St. Hollis</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |
| DATE <u>MAY 12 1967</u> | | | | | | 23. Md. | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06451

CERTIFICATE OF DEATH

06450

| | | | | | |
|---|------------------------------------|--|---|--|---|
| 1 PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE MARYLAND b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN 1b
2 DAYS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | d. STREET ADDRESS
721 NORTH FREMONT AVENUE | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3 NAME OF DECEASED (Type or print)
First Middle Last
THOMAS ISAAC WALLACE | | | 4 DATE OF DEATH
Month Day Year
MAY 22, 19 67 | | |
| 5 SEX
MALE | 6 COLOR OR RACE
NEGRO | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8 DATE OF BIRTH
JUNE 18, 1893 | | 9 AGE (in years last birthday) yrs.
73 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
DISPLAYER | | 10b. KIND OF BUSINESS OR INDUSTRY
DEPARTMENT STORE | | 11. BIRTHPLACE (County & State, or foreign country)
CALVERT COUNTY, MARYLAND | |
| 13 FATHER'S NAME
WILLIAM H. WALLACE | | | 14. MOTHER'S MAIDEN NAME
AMELIA E. COOKE | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW-1 | | 16. SOCIAL SECURITY NO
212 09 90 56 | | 17 INFORMANT
Address
CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
H.C.T. DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) | | | | | INTERVAL BETWEEN ONSET AND DEATH
RECENT |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from May 20, 1967 , to May 22, 1967 , that (I) (we) last saw the deceased alive on MAY 22, 19 67 , and that death occurred at 12:45 a. M. from causes and on the date stated above | | | | | |
| 22a SIGNATURE
<i>Howard C. Kramer</i> | | M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b DATE SIGNED
5/22/67 | |
| 22c PHYSICIAN'S NAME (Type)
HOWARD C. KRAMER, M. D. | | 22d ADDRESS
VAH FORT HOWARD, MARYLAND | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b DATE THEREOF
5-24-67 | 23c NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d LOCATION (City or town) (County) (State)
BALTIMORE, MARYLAND | |
| 24 FUNERAL DIRECTOR | | 25a REC'D BY REGISTRAR
ELROY O WILSON FUNERAL HOME | | 25b REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06452

CERTIFICATE OF DEATH

06441

| | | | | | |
|--|--|--|--|--|---|
| 1 PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | 2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission)
a. STATE Maryland b. COUNTY ✓ | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY in 1b
129 Days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | | d. STREET ADDRESS
2925 E. Baltimore Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3 NAME OF DECEASED (Type or print)
First WILLIAM Middle JOHN Last WALTON | | | 4 DATE OF DEATH
Month MAY Day 28 Year 19 67 | | |
| 5. SEX
Male | 6 COLOR OR RACE
White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/5/91 | 9 AGE in years (last birthday)
75 yrs | 10 UNDER 1 YEAR
Months 12 Days 19 Hours 67 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machine Nail Helper | | 10b. KIND OF BUSINESS OR INDUSTRY
Steel | 11 BIRTHPLACE (County & State, or foreign country)
Baltimore County, Maryland | | 12 CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13 FATHER'S NAME
William T. Walton | | | 14 MOTHER'S MAIDEN NAME
Florence Fuller | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)
Yes WW I | | 16 SOCIAL SECURITY NO.
213-09-15-71 | 17 INFORMANT
Clin. Rec. VA Hospital, Fort Howard, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
DUE TO (b) DIABETES MELLITUS
DUE TO (c) LESS THAN 10 DAYS
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
260X | | | | | INTERVAL BETWEEN ONSET AND DEATH
YEARS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
PERIPHERAL VASCULAR INSUFFICIENCY | | | | | 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that box (this hospital) attended the deceased from January 19, 19 67 , to May 28, 19 67 , that box (we) last saw the deceased alive on May 28, 19 67 , and that death occurred at 5:50AM from causes and on the date stated above | | | | | |
| 22a. SIGNATURE
<i>John W. Payne</i> | | 22b. DATE SIGNED
5/28/67 | | 22c. PHYSICIAN'S NAME (Type)
JOHN W. PAYNE, M.D. | |
| 22d. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | | 22e. DATE SIGNED
5/28/67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
5/31/67 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | 23d. LOCATION (City or Town)
Baltimore, Md. | (County) | (State) |
| 24. FUNERAL DIRECTOR
J.A. Moran Funeral Home | | 25a. DECEASED BY REGISTRAR
3600 E. Balto. St. Baltimore, Maryland | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

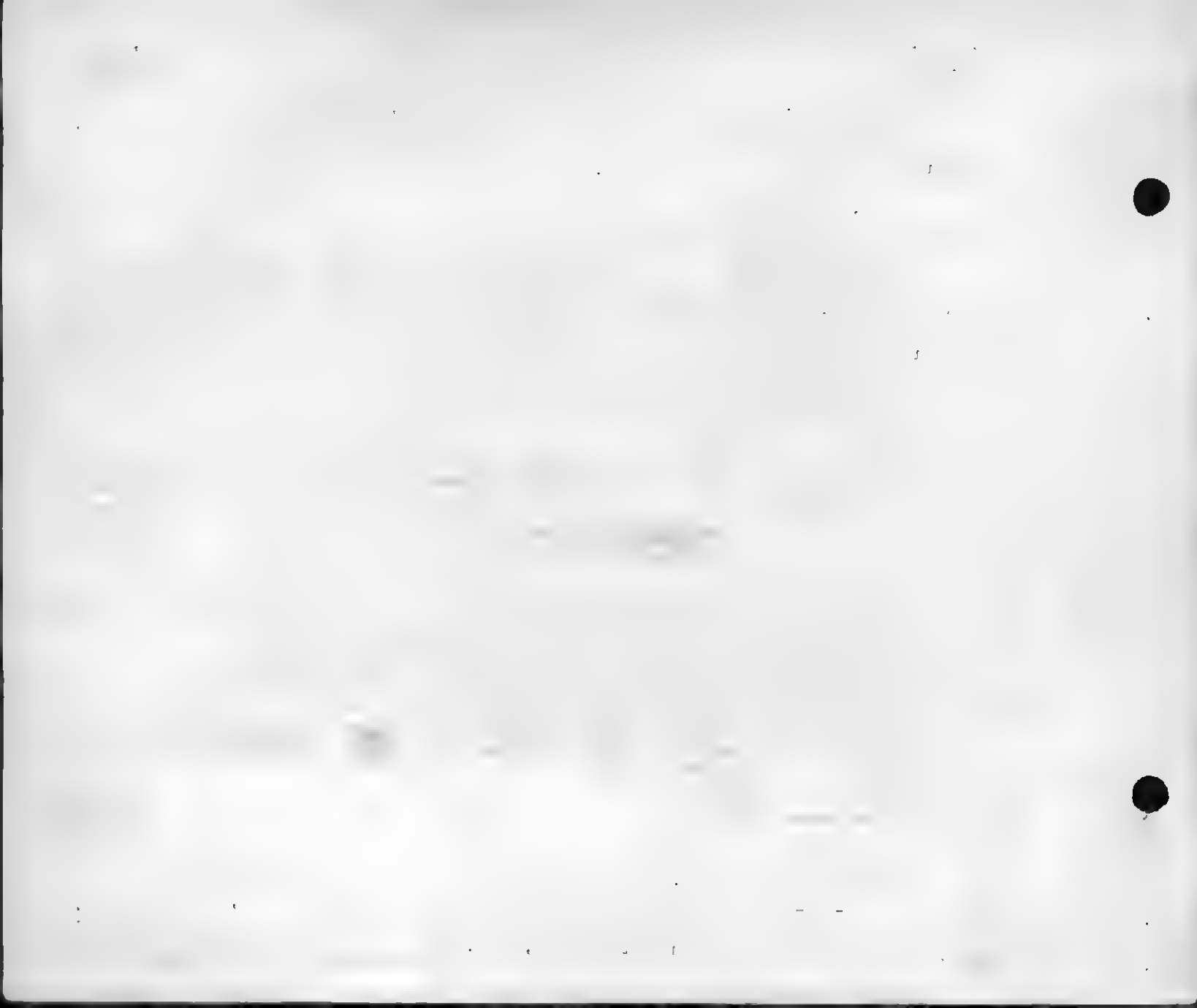
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16442

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>
c. LENGTH OF STAY IN <u>31 1/2 yrs.</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Robb Nursing Home</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>
d. STREET ADDRESS <u>8310 Liberty Road</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Anna</u>
First Middle Last
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 28 1907</u>
<u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/> <u>3-1-1872</u>
9. AGE (In years, last birthday) <u>95 yrs.</u> IF UNDER 1 YEAR: Months <u>95</u> Days <u>95</u> Hours <u>95</u> Min <u>95</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Henry Thune</u>
14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>
16. SOCIAL SECURITY NO. <u>None</u>
17. INFORMANT <u>Helen Marsh - 3521 Abbie Place</u> Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
DUE TO (b) <u>Hypertension</u>
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Hypertension</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>18 yrs.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u>19</u>
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town, County, State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 15, 1967</u> to <u>May 18, 1967</u> that (I) (we) last saw the deceased alive on <u>May 15, 1967</u> and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Edward Thompson</u>
22c. PHYSICIAN'S NAME (Type) <u>Edward Thompson</u> M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>
23b. DATE THEREOF <u>5-31-67</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>
23d. LOCATION (City, town or county, State) <u>Baltimore, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>MAY 31 1967</u>
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

36454

CERTIFICATE OF DEATH

36443

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Burwood Ct.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>
d. STREET ADDRESS <u>Burwood Ct.</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>James</u> Middle <u>Griffis</u> Last <u>Watkins</u> | | | | 4. DATE OF DEATH
Month <u>May</u> Day <u>6</u> , Year <u>1967</u> | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Jan. 1, 1919</u> | | 9. AGE (In years last birthday) <u>48</u> yrs.
IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>
IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President Top Crafts Inc.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Smithville, Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME
<u>James R. Watkins</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mattie Griffis</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | | | 16. SOCIAL SECURITY NO. <u>217-07-7916</u> | | 17. INFORMANT Address <u>Mrs. Lavinia D. Watkins Lutherville, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>171X Carcinoma of lung</u>
DUE TO (b) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u> </u>
DUE TO (c) <u> </u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from <u>2/3 1967</u> , to <u>5/6 1967</u> , that (I) (we) last saw the deceased alive on <u>5/6 1967</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>Milton B. Kirsh</u> | | | | 22b. ADDRESS
<u>4000 W. Northern Parkway - Baltimore, Md.</u> | | 22c. DATE SIGNED
<u>5/6/67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Milton B. Kirsh, M.D.</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF
<u>May 9, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Druid Ridge Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Pikesville, Md.</u> | | | |
| 24 FUNERAL DIRECTOR'S SIGNATURE
<u>J. F. Eline & Sons</u> | | | | ADDRESS
<u>Reisterstown, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 9 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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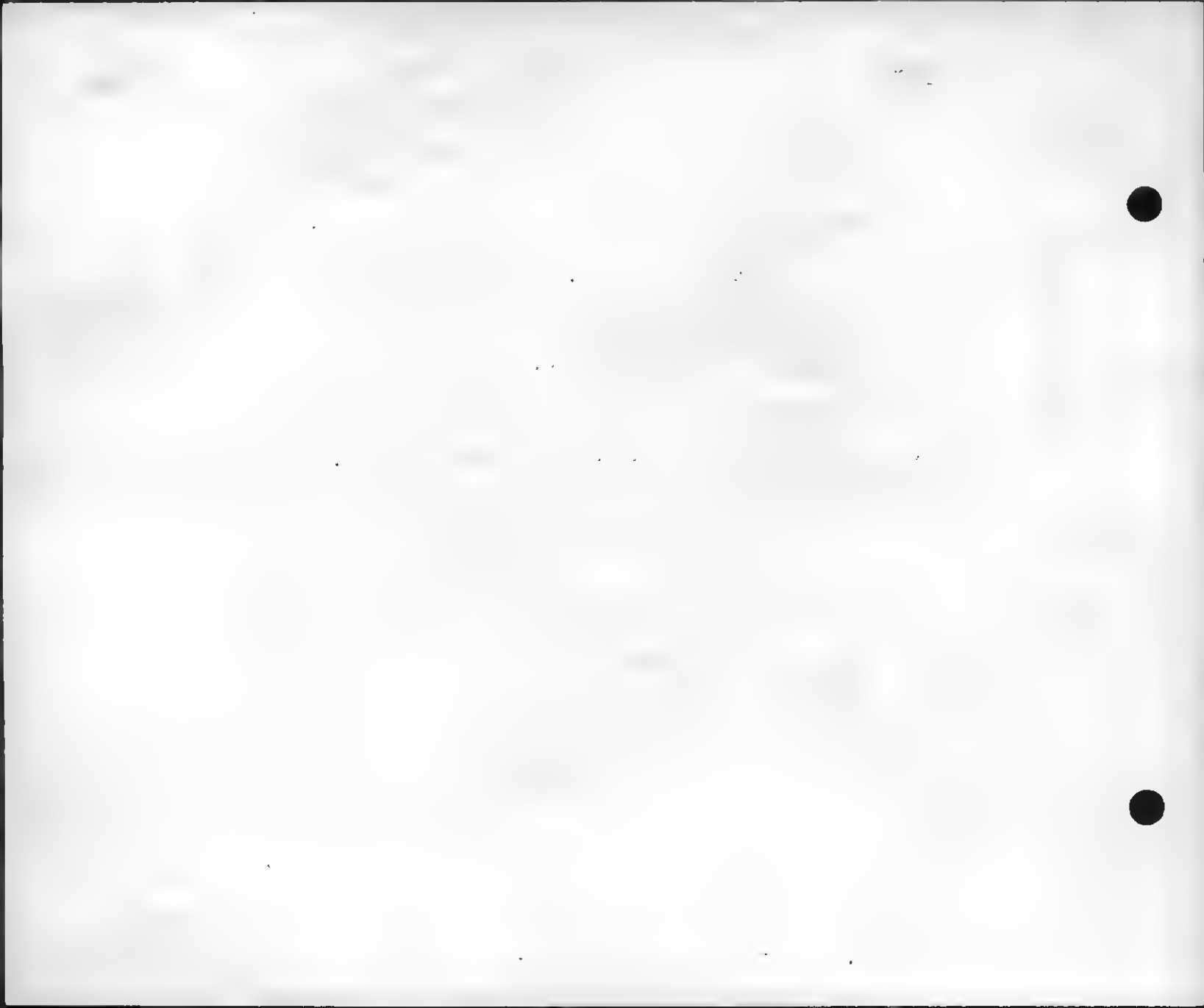
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06455

CERTIFICATE OF DEATH

06444

| | | | | | | | |
|---|---------------------------------|---|------------------------------------|--|---------------------------|--|---|
| 1 PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto. | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | | c LENGTH OF STAY IN 1b | | | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
2915 Ohio Ave. 21227 | | | | d STREET ADDRESS
2915 Ohio Ave. 21227 | | | |
| 3. NAME OF DECEASED (Type or print)
First George Middle W. Last Westphal | | | | 4 DATE OF DEATH
Month May Day 20 Year 19 67 | | | |
| 5. SEX
Male | 6 COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/15/05 | 9 AGE (In years last birthday)
61 yrs. | IF UNDER 1 YEAR
Months | IF UNDER 24 HRS
Days | Hours |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Paper Cutter | | 10b KIND OF BUSINESS OR INDUSTRY
Eickeberg Co. | | 11 BIRTHPLACE (County & State or foreign country)
Maryland | | 12 CITIZEN OF WHAT COUNTRY?
USA | |
| 13 FATHER'S NAME
Charles Westphal | | | | 14 MOTHER'S MAIDEN NAME
Nellie Brandt | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW II | | 16 SOCIAL SECURITY NO
214-03-2055 | | 17. INFORMANT Address
Mr. Wilbur L. Polk 2915 Ohio Ave. 21227 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ac. Coronary Occlusion
DUE TO A.S.C.V.D.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
(b) DUE TO
(c) DUE TO | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10:30 , 19 67 to 5:17 , 19 67 , that (I) (we) last saw the deceased alive on 5/21 , 19 67 and that death occurred at 6 P.M. from causes and on the date stated above. | | | | | | | |
| 22a SIGNATURE
Justin Kudirka | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b DATE SIGNED
5-22-67 | |
| 22c PHYSICIAN'S NAME (Type)
Justin Kudirka | | | | 22d ADDRESS
2151 Wilkens Ave. | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b DATE THEREOF
5/24/67 | | 23c NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24 FUNERAL DIRECTOR
Howard H. Hubbard | | ADDRESS
4107 Wilkens Ave. 21229 | | 25a REC'D BY REGISTRAR
MAY 23 1967 | | 25b REGISTRAR'S SIGNATURE
Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

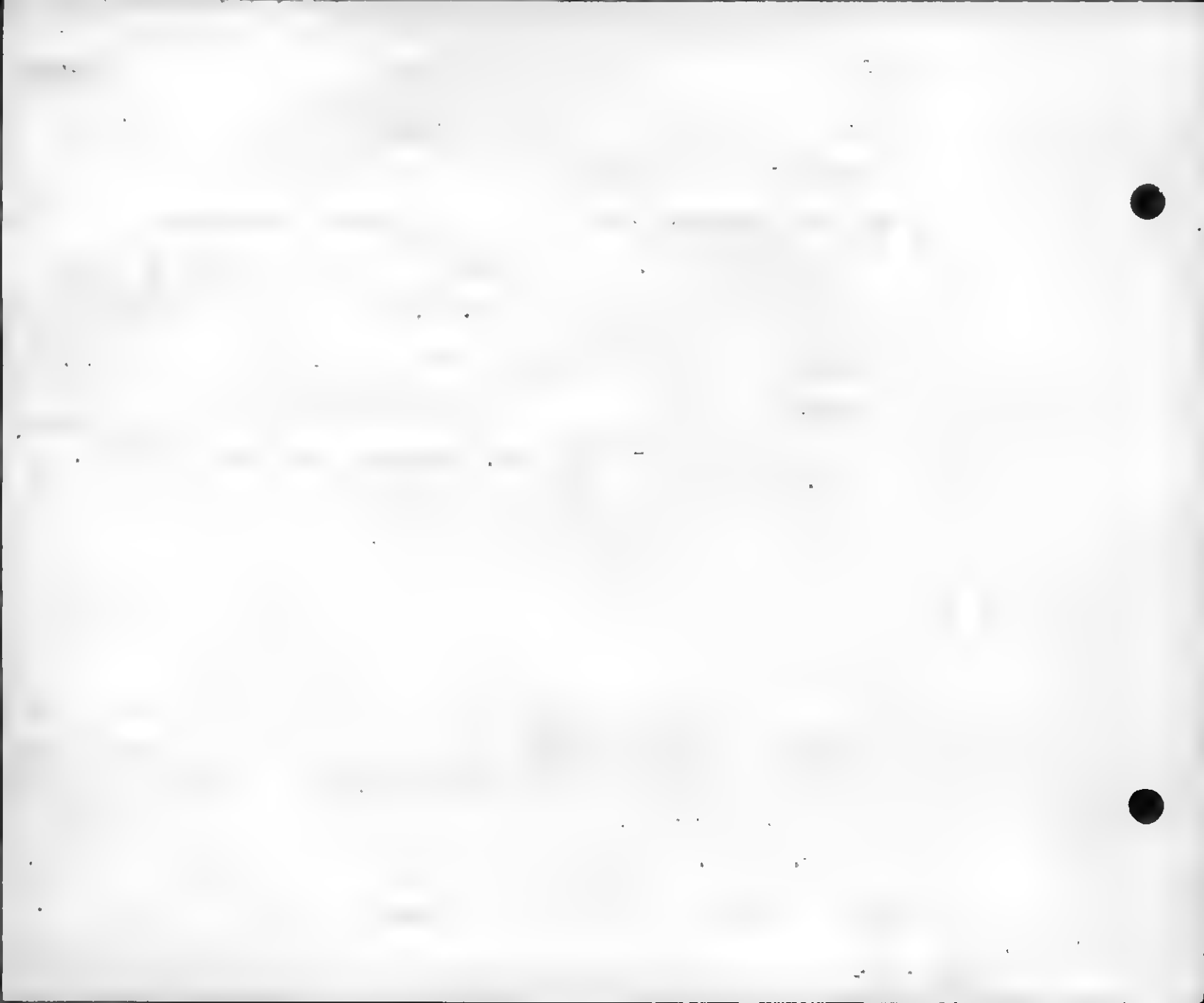
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06456

CERTIFICATE OF DEATH

55115

| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH
a COUNTY Baltimore
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE Maryland
b COUNTY Baltimore | |
| c LENGTH OF STAY IN b 45yrs | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 337 Rte 2 Deer Park Road | | d. STREET ADDRESS Box 337 Rt 2 Deer Park Road | |
| e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print)
First Middle Last
Cecelia T. White | | 4 DATE OF DEATH
Month Day Year
May 18 1967 | |
| 5. SEX
Female | 6 COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 24, 1888 |
| 9. AGE (In years lost day) 79 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Owner-Florist | | 10b. KIND OF BUSINESS OR INDUSTRY
Florist Business | |
| 11. BIRTHPLACE (County & State, or foreign country)
Chicago, ILL. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
(unknown) | | 14. MOTHER'S MAIDEN NAME
Hattie Whitley | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO
217-32-9782 | |
| 17. INFORMANT
Mrs. Frieda Meginnis | | Box 337 Rt 2 Deer Pk Rd. Owings Mills Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiac failure
DUE TO (b) metastatic carcinoma
DUE TO (c) Carcinoma rectum
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (1) (this hospital) attended the deceased from 1962 to May 18, 1967 , that (1) (we) lost saw the deceased alive on May 18 1967 , and that death occurred at 3:30 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
John Darrell | | 22b. DATE SIGNED
5-20-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. John J. Darrell | | 22d. ADDRESS
9017 Liberty Road Randallstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
5/22/67 | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | 23d. LOCATION (City or Town) (County) (State)
Pikesville Balto MD. |
| 24. FUNERAL DIRECTOR
Loring Byers | | 25a. REC'D BY REGISTRAR
Charles Judge | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE MAY 22 1967 | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

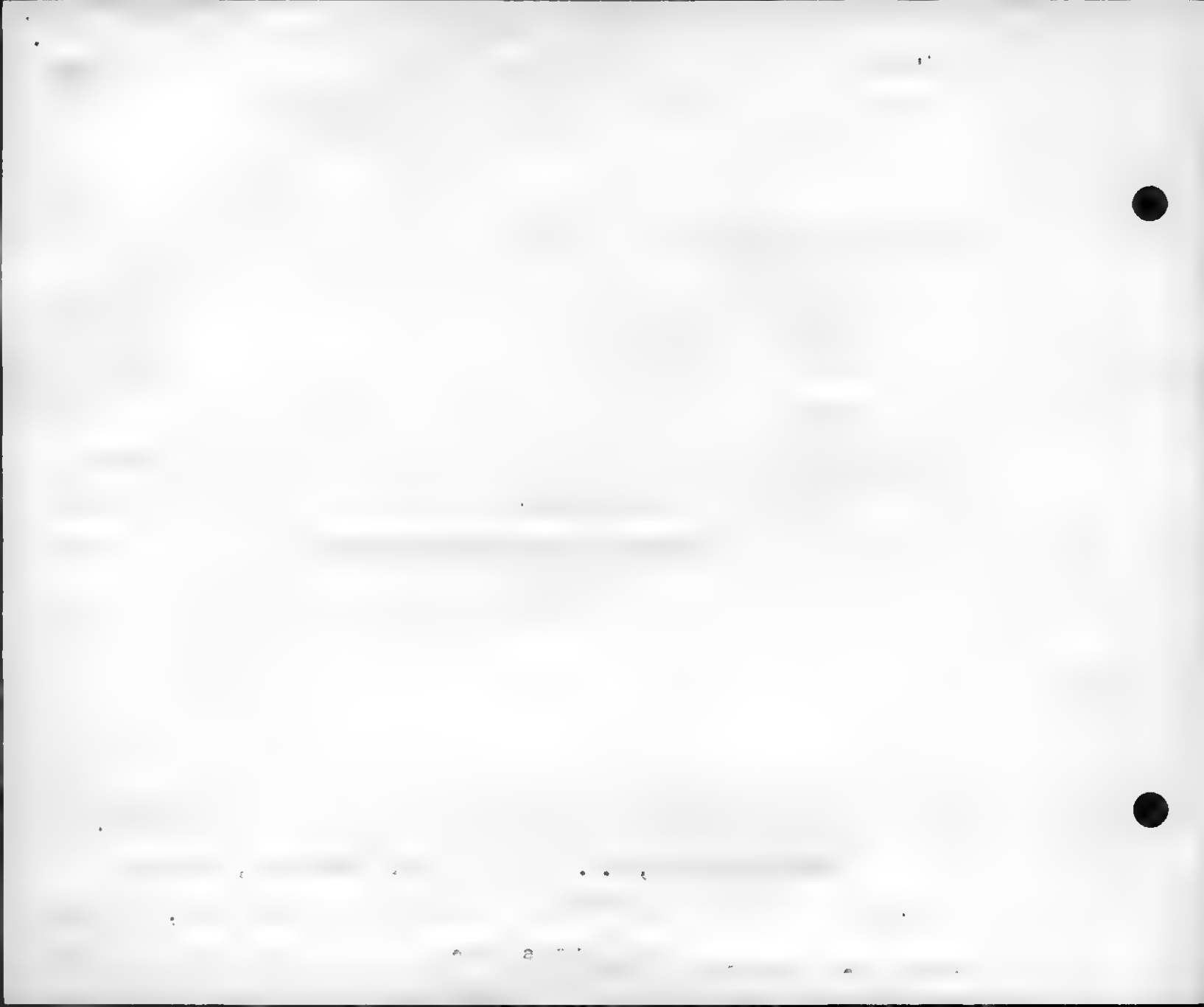
06457

CERTIFICATE OF DEATH

10118

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE MARYLAND b. COUNTY _____ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | | c. LENGTH OF STAY IN IB
15 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE 3014 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS
930 BROOKS LANE | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
VERNON ANTHONY WHITTINGTON | | | | 4. DATE OF DEATH
Month Day Year
MAY 27 19 67 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
AUGUST 27, 1920 | | 9. AGE (In years last birthday)
46 yrs. | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired)
KITCHEN HELPER | | 10b. KIND OF BUSINESS OR INDUSTRY
SUN PAPERS | | 11. BIRTHPLACE (County & State or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JAMES WHITTINGTON | | | | 14. MOTHER'S MAIDEN NAME
MARY WHITTINGTON | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW-11 | | 16. SOCIAL SECURITY NO.
216 12 23 54 | | 17. INFORMANT Address
CLIN. REC., VAH, FT. HOWARD, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC FAILURE
4344 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIAC DISEASE, UNKNOWN ETIOLOGY DUE TO
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 9. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (home, farm, factory, street, office bldg, etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (A) (this hospital) attended the deceased from May 12 19 67 , to May 27 19 67 , that (H) (we) last saw the deceased alive on May 27 19 67 , and that death occurred at 12:00 P. M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>John Walter Payne</i> | | | | 22b. DATE SIGNED
5/28/67 | | 22c. PHYSICIAN'S NAME (Type)
JOHN WALTER PAYNE, M.D. | |
| 22d. ADDRESS
VAH, FORT HOWARD, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
5-31-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | | 23d. LOCATION (City or town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
Morton & Dyett Funeral Home Baltimore, Maryland | | | | 25a. REC'D BY REGISTRAR
DAT MAY 31 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

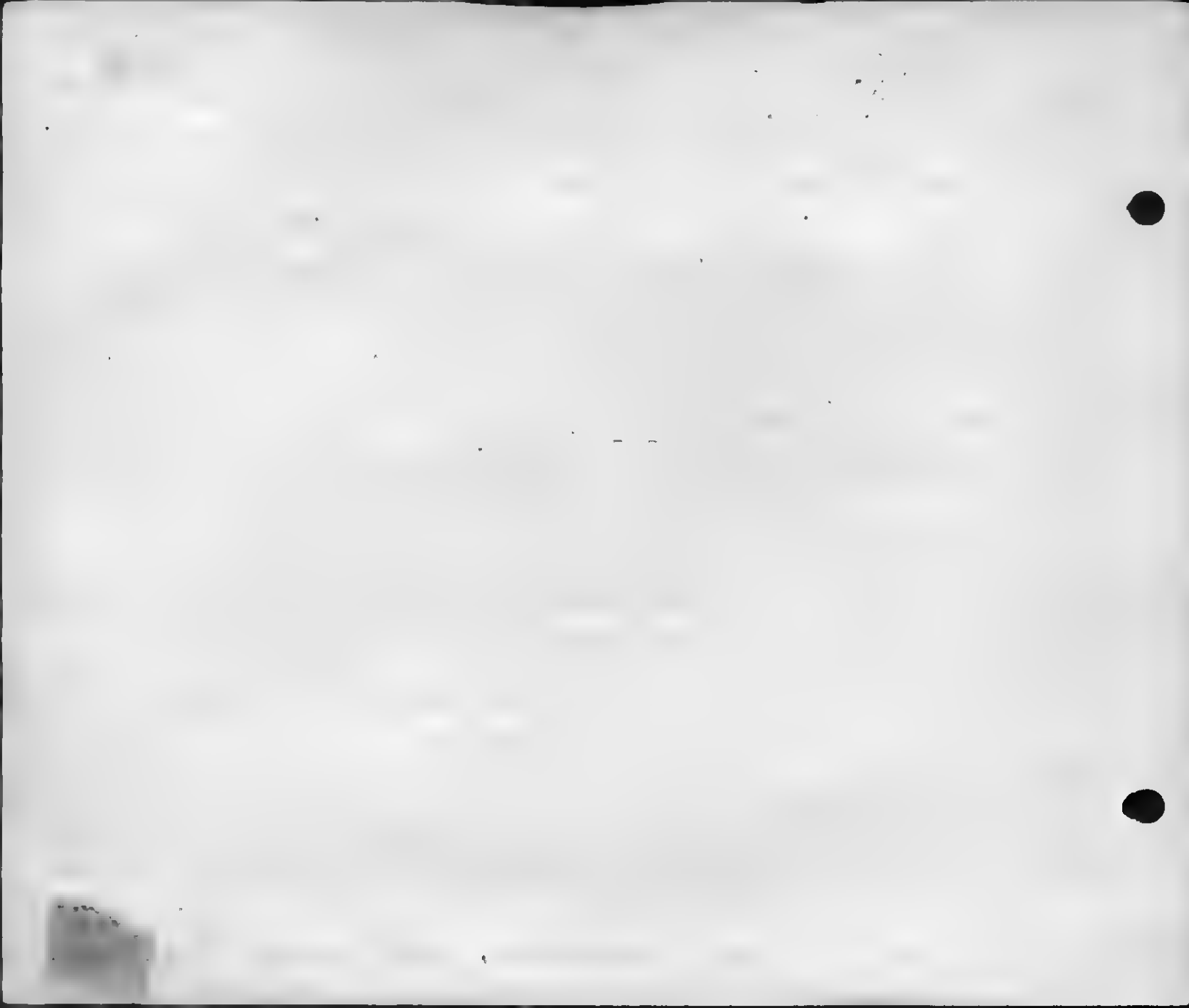
CERTIFICATE OF DEATH

06458

06147

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | |
|--|------------------|---|------------------|--|------|-------|------|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto. Co.</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Upperco</u>
c. LENGTH OF STAY IN 1b <u>MARYLAND</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dover Rd.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Balto. Co.</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Upperco</u>
d. STREET ADDRESS <u>Dover Rd.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Herman B. Wickline</u> | | 4. DATE OF DEATH
Month <u>May</u> Day <u>18</u> Year <u>1967</u> | | 5. SEX
<u>Male</u> | | | | | | | |
| 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>April 29, 1906</u> | | | | | | | |
| 9. AGE (In years last birthday) <u>61</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table> | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | Months | Days | Hours | Min. | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Mechanic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Garage</u> | |
| IF UNDER 1 YEAR | IF UNDER 24 HRS. | | | | | | | | | | |
| Months | Days | | | | | | | | | | |
| Hours | Min. | | | | | | | | | | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>West Va.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>James W. Wickline</u> | | | | | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Lenna Dameron</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>189-09-6639</u> | | | | | | | |
| 17. INFORMANT
<u>Mrs. May Wickline</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Thyroidogenic Carcinoma</u>
DUE TO <u>Emphysema</u>
(b) <u>Emphysema</u>
(c) <u>Emphysema</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 year</u>
<u>2 years</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner) <input type="checkbox"/> | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | | | | | | | |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from February 1946 to May 18, 1967, that (I) (we) last saw the deceased alive on May 17, 1967, and that death occurred at 11:45 AM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>E. M. S. Wickline</u> | | 22b. DATE SIGNED
<u>5-18-67</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>E. M. S. Wickline</u> | | | | | | | |
| 22d. ADDRESS
<u>11904 Reisterstown Rd Reisterstown Md</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | | | | | | |
| 23b. DATE THEREOF
<u>5/21/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Pleasant Grove Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Upperco Balto. Co. Md.</u> | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Tipton - Eline Funeral Home Hampstead, Md.</u> | | 25a. REC'D BY REGISTRAR
<u>MAY 22 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36459

CERTIFICATE OF DEATH

06118

| | | | | | | | |
|--|----------------------------------|---|------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | c. LENGTH OF STAY IN 1b
<u>2 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore - md. 21230</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Greater Balto. Medical Center.</u> | | | | d. STREET ADDRESS
<u>1214 Patapsco Street.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
<u>George F Widmer</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>May 29 1967</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3-28-98</u> | | 9. AGE (In years lost birthday)
<u>69</u> yrs | 10. UNDER 1 YEAR Months Days
11. UNDER 24 HRS Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired paper litter</u> | | 10b. KIND OF BUSINESS OR IND. STRY
<u>Grinnell Co.</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Buffalo, New York</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>George Widmer Sr.</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Burch Gertrude</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no none</u> | | 16. SOCIAL SECURITY NO. <u>215-09-7802</u> | | 17. INFORMANT Address
<u>Pl's. Chantaura Widmer-1214 Patapsco St.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) <u>METASTATIC CA. RECTUM</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>CACHEXIA</u> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5/27</u> , 19 <u>67</u> to <u>5/29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/29</u> , 19 <u>67</u> , and that death occurred at <u>4:40</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Evelyn L. Ramos, M.D.</u> | | | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<u>EVELYN L. RAMOS, M.D.</u> | | | | 22d. ADDRESS
<u>G.B.M.C. Tolson 4</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>June 1/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Meadowridge Cemetery</u> | | 23d. LOCATION (City or town) (County) (State)
<u>Washington Blvd. Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Krause Funeral Home 1216 S. Charles St.</u> | | | | 25a. REC'D BY REGISTRAR
<u>DATE MAY 31 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06460

CERTIFICATE OF DEATH

07-30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission)
a. STATE Maryland b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 'b
4yr3mth4dys | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Spring Grove State Hospital | | e. STREET ADDRESS
2822 Large Farm Road | |
| 3. NAME OF DECEASED (Type or print)
First Cyrus Middle Williams Last Williams | | 4. DATE OF DEATH
Month May Day 24 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 26, 1892 |
| 9. AGE (in years lost birthday)
75 yrs | | 10. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | 11. BIRTHPLACE (County & State, or foreign country)
South Carolina |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Henry Earl Williams | |
| 14. MOTHER'S MAIDEN NAME
Alice | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Unknown | |
| 16. SOCIAL SECURITY NO
213-07-6389 | | 17. INFORMANT
Records: Spring Grove State Hospital | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) Arteriosclerotic cardiovascular disease
DUE TO
(c) Arteriosclerosis, generalized and severe | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 'o'm
p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) | 20f. (City or town) (County) (State) |
| 21. I certify that (this hospital) attended the deceased from 2-20-63 , at 11:20 to May 24, 1967 , that (he) (we) last saw the deceased alive on May 24, 1967 , and that death occurred at P. M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Stella Wachslor | | 22b. DATE SIGNED
5-24-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Stella Wachslor, M.D. | | 22d. ADDRESS
Spring Grove State Hospital
Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
May 29/67 | 23c. NAME OF CEMETERY OR CREMATORY
Int Calvary Cemetery, Catonsville | 23d. LOCATION (City or town) (County) (State) |
| 24. FUNERAL DIRECTOR
Robert E. Williams | | 25. REGISTRATION
1701-123 R. B. 2/2/3 | |

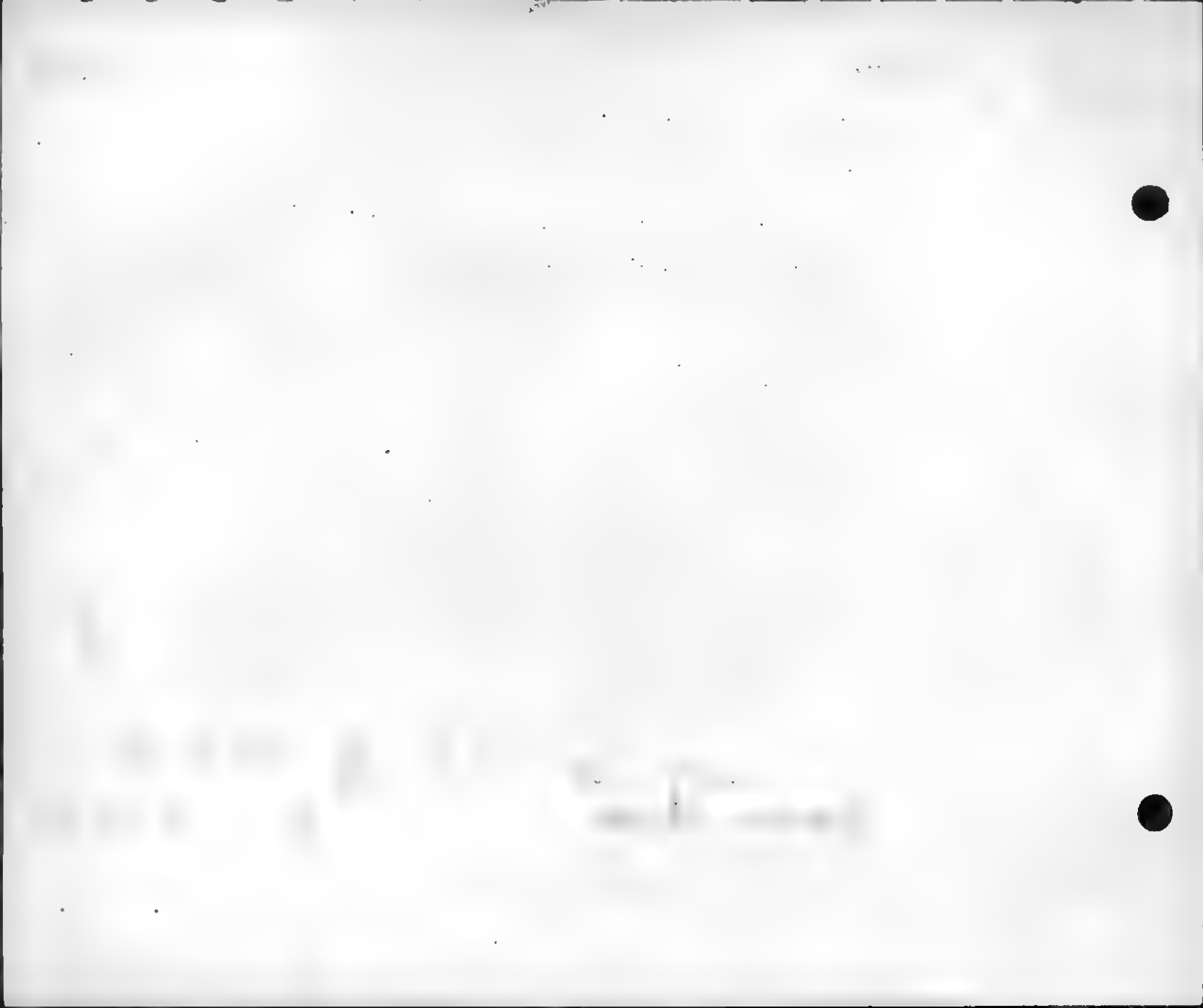


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|---|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | c. LENGTH OF STAY IN 1b <u>404 mos</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> | | b. COUNTY <u>10 Co</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER Baltimore Medical Center</u> | | | | | | d. STREET ADDRESS <u>6531 Corkley Road 6</u> | | | b. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print) <u>William</u> | | First <u>William</u> | | Middle <u>FREDERICK</u> | | Last <u>WISSEL</u> | | 4. DATE OF DEATH <u>MAY 15 1967</u> | | Month <u>MAY</u> Day <u>15</u> Year <u>1967</u> | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>CAUC</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>07-03-07</u> | | 9. AGE (in years last birthday) <u>59</u> yrs. | | IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CATER OPERATOR</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Greene & Sons Corp.</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | |
| 13. FATHER'S NAME <u>William Frederick WISSEL</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>WIEGAND Catherine</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>213-01-6707</u> | | 17. INFORMANT <u>Mrs Evelyn B. Wissel 6531 Corkley Road</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Wide spread tumor metastases</u>
38 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of colon</u>
DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 13</u> , 19 <u>67</u> , to <u>May 15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 15</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> A.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Robert W. Smith</u> | | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> | | MED. DIRECTOR <input checked="" type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | | 22b. DATE SIGNED <u>5-15-67</u> | | | | | |
| 22d. ADDRESS | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>5-18-1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Zion Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Baltimore Co. Md.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u> | | | | ADDRESS <u>7401 Belair Road</u> | | | | 25a. REC'D BY REGISTRAR <u>MAY 17 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

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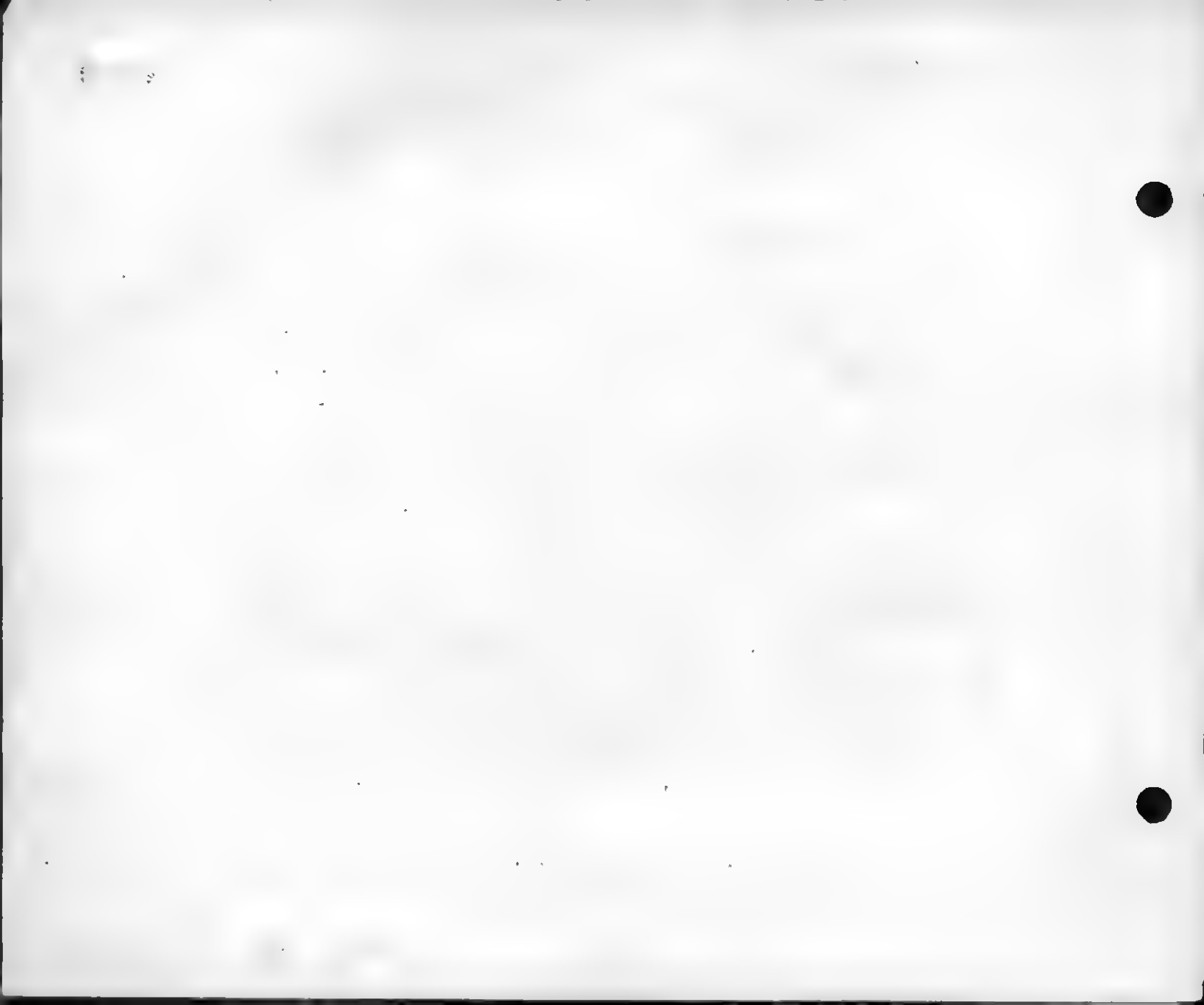
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06462

06450

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| | | | | | | Baltimore 21221 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | | | d. STREET ADDRESS
707 Myrth Avenue | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
First Anna Middle Marie Last Wolf | | | | 4. DATE OF DEATH
Month May Day 3 Year 19 67 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-16-92 | | 9. AGE (In years last birthday)
75 yrs | 10. IF UNDER 1 YEAR
Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
JOHN SEITZ | | | | 14. MOTHER'S MAIDEN NAME
MARY BOEHM | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
UNK | | 16. SOCIAL SECURITY NO.
? | | 17. INFORMANT
HOSP. RECORDS Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Esophagus with Metastasis
X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Hypertensive Cardiovascular disease in Failure. | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not While of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April 10 , 19 67 , to May 3 , 19 67 , that (I) (we) last saw the deceased alive on May 3 , 19 67 , and that death occurred at 12:10AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Ramon P. Lopez | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
May 3, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Ramon P. Lopez | | 22d. ADDRESS
M.D. 7620 York Road- Towson 21204, Maryland. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
CRIMINAL | | 23b. DATE THEREOF
5/6/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Cath Town | | 23d. LOCATION (City or Town) (County) (State)
Balt Md | |
| 24. FUNERAL DIRECTOR
Connelly Lane 300 more | | | | 25a. REC'D BY REGISTRAR
DATE MAY 5 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

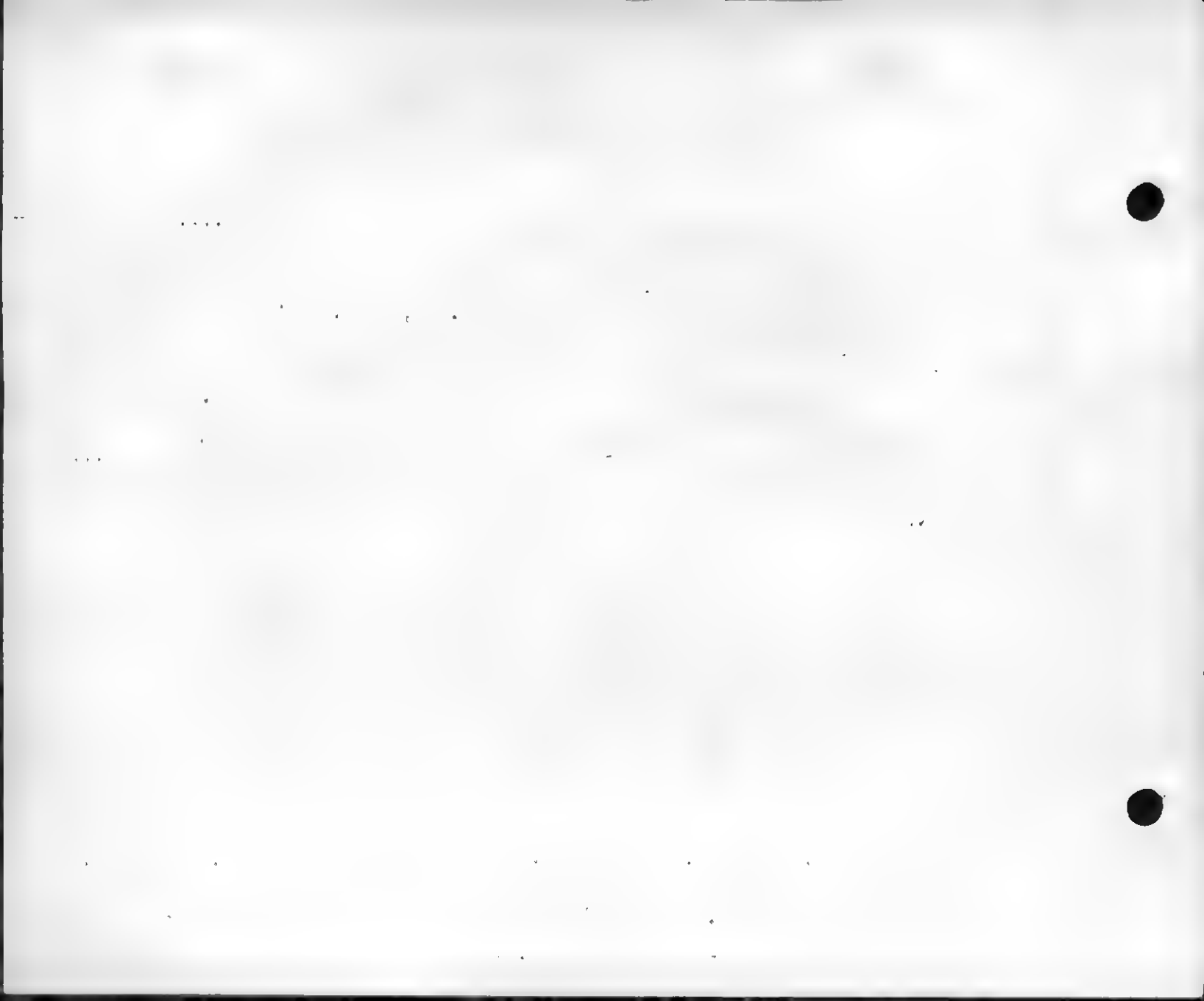
CERTIFICATE OF DEATH

06465

06451

| | | | |
|--|---------------------------------|--|--|
| 1 PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission)
a. STATE Maryland
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Dulaney-Towson Nursing & Convalescent Home | | d. STREET ADDRESS
5815 Willowton Ave....14 | |
| 3 NAME OF DECEASED
(Type or print) E D N A P. Y O U N G | | 4 DATE OF DEATH
Month May Day 7 Year 1967 | |
| 5 SEX
female | 6 COLOR OR RACE
white | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH
Feb. 16, 1890. |
| 9 AGE (In years last birthday) yrs 77 | | 10 UNDER 1 YEAR
Months Days | 11 UNDER 24 HRS
Hours Min. |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (County & State or foreign country)
Maryland | | 12 CITIZEN OF WHAT COUNTRY?
USA | |
| 13 FATHER'S NAME
Clarence Pentz | | 14. MOTHER'S MAIDEN NAME
Laura C. Parsons | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No (If yes give war or dates of service) | | 16 SOCIAL SECURITY NO
214-01-4369B | |
| 17 INFORMANT
Harry A. Young--5815 Willowton Ave....14 | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Carcinoma of Breast - Metastasis
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
3 yrs |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Arteriosclerosis, Coronary Artery Disease, Atherosclerosis | | | |
| 19 WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) | |
| 20c TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 3, 1967 to May 7, 1967 , that (I) (we) last saw the deceased alive on May 3, 1967 , and that death occurred at 1:30 A.M. , from causes and on the date stated above. | | | |
| 22a SIGNATURE
Dr. Thomas J. Worsley, Jr. | | 22b DATE SIGNED
5/8/67 | |
| 22c PHYSICIAN'S NAME (Type)
Dr. Thomas J. Worsley, Jr. | | 22d ADDRESS
2900 Alameda...Balto...d. | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b DATE THEREOF
5/9/67. | |
| 23c NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24 FUNERAL DIRECTOR
Leonard J. Ruck, Inc.--Baltimore, Md....14 | | 25a REC'D BY REGISTRAR
DATE MAY 8 1967 | |
| | | 25b REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY, CAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M. 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
06463 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06452

| | | | |
|--|--------------------------------------|--|---|
| 1. PLACE OF DEATH
COUNTY Baltimore
M | | 2. USUAL RESIDENCE (When deceased lived, if institution; Residence before admission)
a. STATE MD. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
7464 Berkshire Rd. # 21224 . | | d. STREET ADDRESS
7464 Berkshire Rd. # 21224 . | |
| 3. NAME OF DECEASED
(Type or print) JOSEPH ZAMENSKI | | 4. DATE OF DEATH
Month May Day 14 , Year 1967. | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
January 16, 1893 |
| 9. AGE (In years last birthday) 74 yrs. | | 10. IF UNDER 1 YEAR
Months 14 Days 19 Hours 67. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 11b. KIND OF BUSINESS OR INDUSTRY
Electrician | |
| 11c. BIRTHPLACE (State or foreign country)
Pittsburgh , Pa. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Frank Zamenski | | 14. MOTHER'S MAIDEN NAME
Stanislawa Jaworowicz | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 705-03-5072 | |
| 17. INFORMANT
Mrs. Gertrude F. Smiley | | Address Same. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion
4201 DUE TO arteriosclerotic Heart
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Disease | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Asthmatic Bronchitis | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month May Day 19 Year 1967
Hour a.m. p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Theodore C. Patterson | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
Theodore C. Patterson | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | 105 Main St. | |
| Address (Street, city, town, or county)
Dundalk , Md. # 21222. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
5-17-67. | 22c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | 22d. LOCATION (City, town, or country) (State)
5829 Ritchie Highway, A.A. Co., Md |
| 23. FUNERAL DIRECTOR
Charles L. Zailer | | 24a. REC'D BY REGISTRAR
MAY 17 1967 | |
| 24b. REGISTRAR'S SIGNATURE
Charles L. Zailer | | 24c. ADDRESS
901 S. Conkling St. Baltimore , 21224, Md. | |

SCULPTURE

9. SSN 123-45-6789

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1. *Journal of the American Medical Association*, 1997; 277: 1039-1043.

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Journal of Management Education

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06464

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06453

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Balto. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Randallstown | | c. LENGTH OF STAY IN 1b
8 hrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Chapel Hill Nursing Home | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Robert H. Zittinger | | 4. DATE OF DEATH
Month May Day 2 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 30, 1890 |
| 9. AGE (In years last birthday)
76 yrs. | | 10. IF UNDER 1 YEAR
Months 76 Days 76 Hours 76 Min. 76 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Collector | | 10b. KIND OF BUSINESS OR INDUSTRY
Gunther Brewery Co. | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George H. Zittinger | | 14. MOTHER'S MAIDEN NAME
Caroline Hauser | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
216-05-4032 | |
| 17. INFORMANT
Mrs. Marie S. Zittinger | | Address Balto. 34
1517 Clearwood Rd., | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Decompensated Arteriosclerotic C-V Disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Hremia
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
1 1/2 yrs.

2 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Emphysema- Mild Diabetes | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH none | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. none p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Noturol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE D. D. Caples | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) D. D. Caples, M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 6 Hanover Rd., Red Bank, Md. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22. DATE SIGNED 5-3-67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
5/5/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE MD. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc., 5305 Harford Rd., Balto. | | 25a. REC'D BY REGISTRAR
MAY 5 1967 | |
| 25b. REGISTRAR'S SIGNATURE
John J. J... | | | |

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